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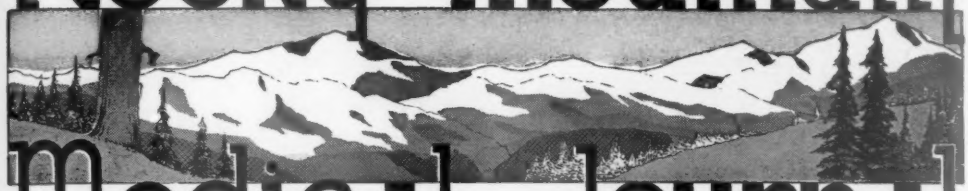

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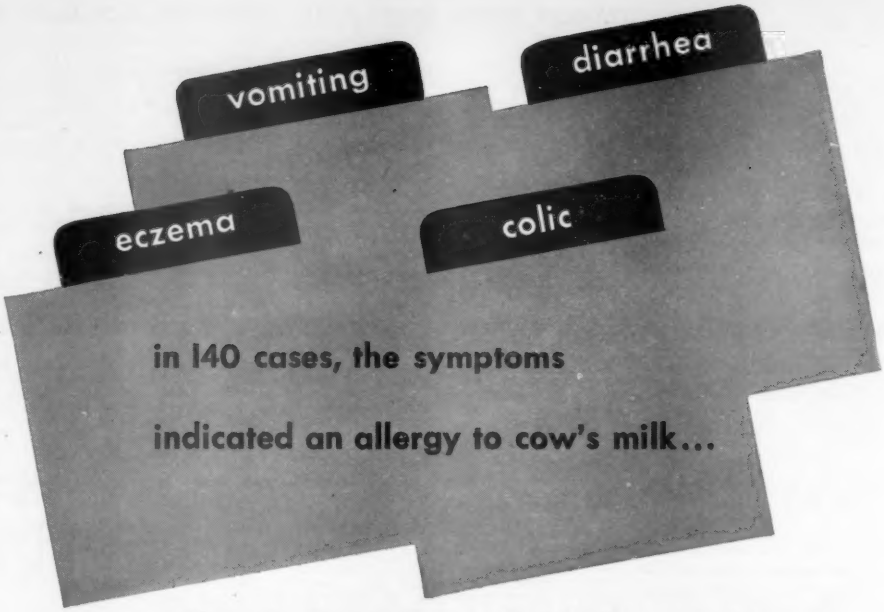

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THE UTAH STATE MEDICAL ASSOCIATION

NEXT ANNUAL SESSION, SALT LAKE CITY, SEPTEMBER 4, 5, 6, 1952

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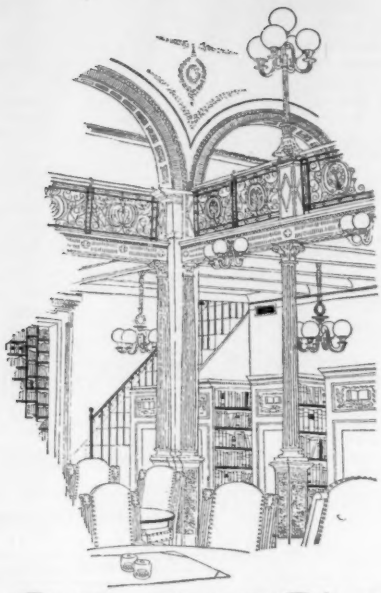
Gerontology Committee: Richard P. Middleton, Chairman, Salt Lake City.



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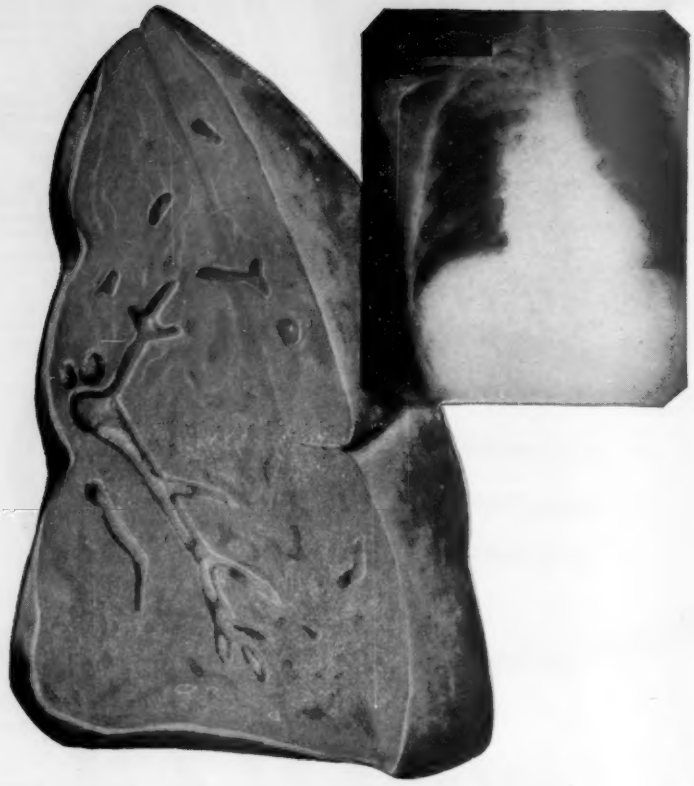
Resolutions: Sister Mary Raymond, Mercy Hospital, Denver; James A. Harrison, Community Hospital, Boulder.



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GRAM-POSITIVE BACTERIAL INFECTIONS

Lobar pneumonia • Mixed bacterial pneumonias
Bacteremia and septicemia
Acute follicular tonsillitis
Septic sore throat • Pharyngitis
Acute and chronic otitis media
Acute bronchitis • Laryngotracheitis
Tracheobronchitis • Sinusitis
Chronic bronchiectasis
Pulmonary infections associated
with pancreatic insufficiency
Scarlet fever • Urinary tract infections
Acute and subacute purulent conjunctivitis
Acute catarrhal conjunctivitis
Chronic blepharoconjunctivitis
not involving the meibomian gland
Abscesses • Cellulitis
Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

GRAM-NEGATIVE BACTERIAL INFECTIONS

Gonorrhea • Brucellosis
Bacteremia and septicemia
Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

SPIROCHETAL INFECTIONS

Syphilis • Yaws • Vincent's infection

RICKETTSIAL INFECTIONS

Epidemic typhus • Murine typhus
Scrub typhus • Rickettsialpox
Q fever • Rocky Mountain spotted fever

VIRAL INFECTIONS

Primary atypical pneumonia (virus pneumonia)
Lymphogranuloma venereum • Trachoma

PROTOZOAL INFECTIONS

Amebiasis

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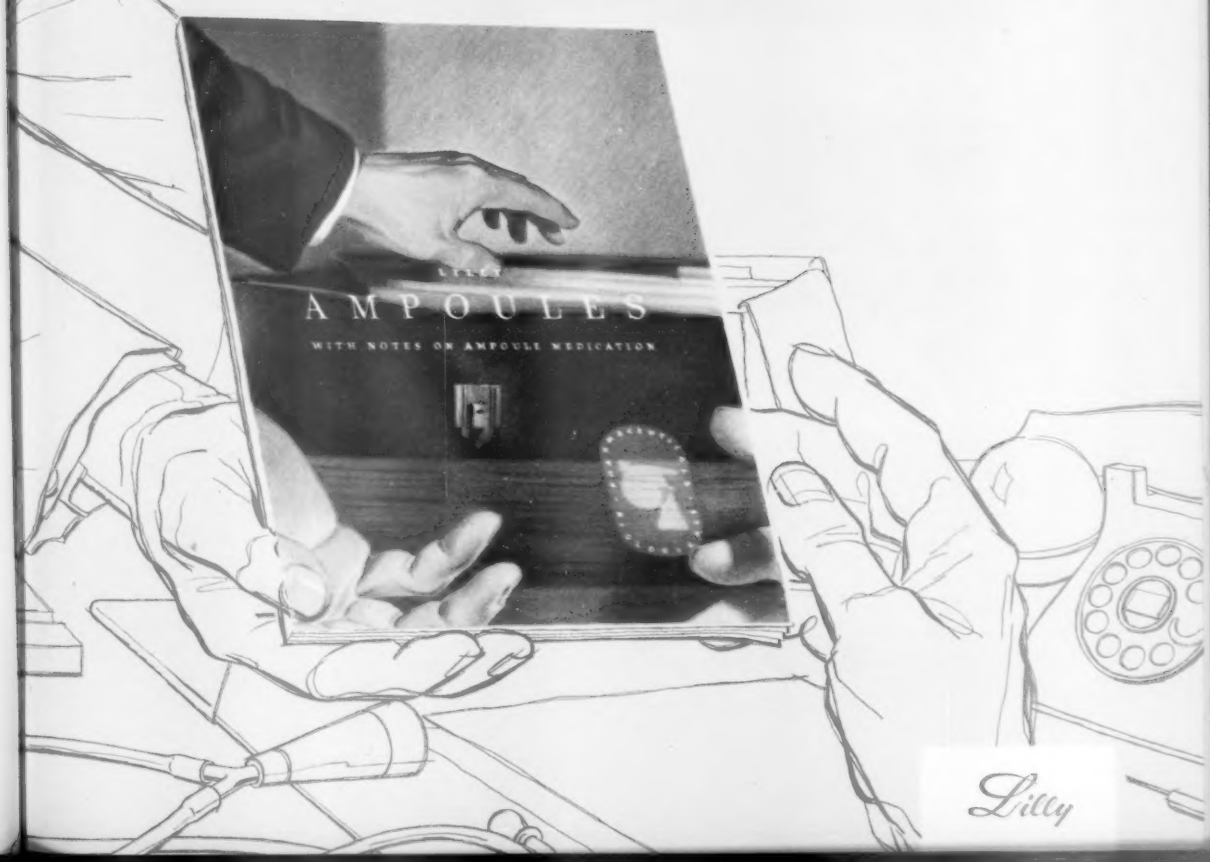

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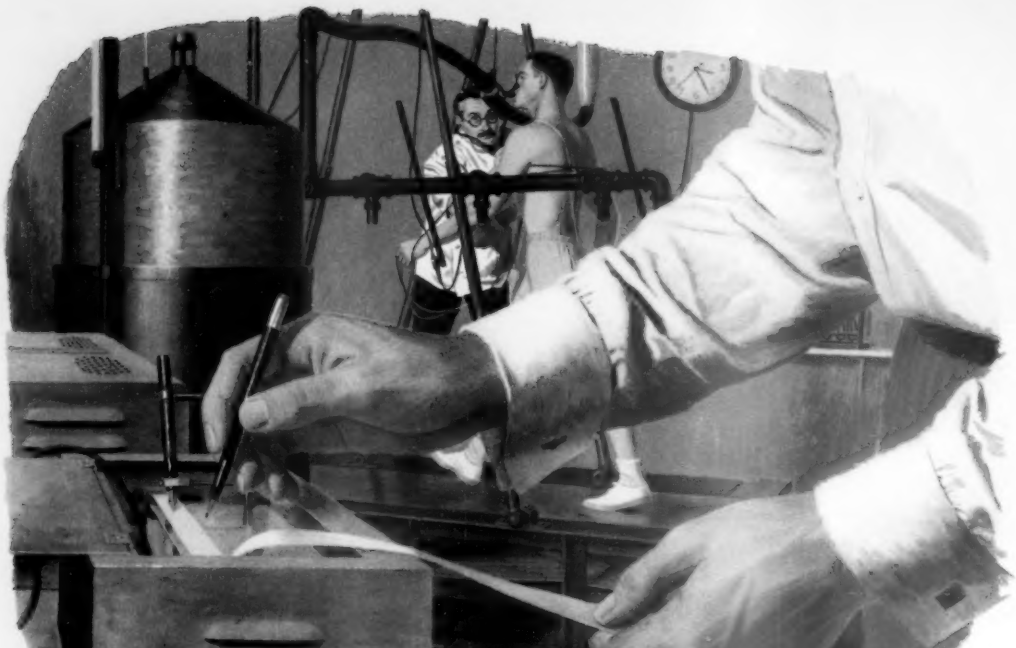

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Rocky Mountain Medical Journal
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1952

Editorial

Danger Ahead!

PHYSICIANS and secretaries are being called upon more and more to fill out forms, blanks, and reports of every description. This is true in all, but particularly in the surgical, specialties.

The majority of patients at the present time are covered or partially covered by some form of insurance. There are Blue Cross and Blue Shield, private, company, fraternal, church and other forms of protective enterprises. Most of them are well established, time-tried and dependable projects. But others are low-premium mail-order contracts which do not seem to be worth the paper upon which they are printed. They have been oversold, if not misrepresented, by their vendors. They contain antiquated fee schedules which were never fair and equitable, even before the advent of Roosevelt and Truman dollars. Furthermore, they contain fine print which releases the organization from many, if not all, significant financial obligations.

Patients are given a false sense of security by many of these mail-order policies. They often pay premiums faithfully for years, meeting courtesy while the money passes from their hands to those of the vendor. Then comes the time of need, and misrepresentation and inadequacy of coverage is exposed. With pride and confidence the patient presents his policy or the forms to be filled out to his physician. Perhaps he has not mentioned this phase of the transaction prior to its impending conclusion. Then if it does not pay his way, he is angry at everyone concerned. Unfortunately he is likely to blame the physician and the hospital rather than the insuror. Unless he is satisfied, a grudge may be held which may sooner or later be expressed in the form of a vote for the Truman Plan or Oscar Ewing's conception of the answer to a nation's health problems.

Anyone of us could cite innumerable examples of the above picture, but two will serve by way of illustration: A man in late middle age had an advanced aggressive cancer involving the lower lip; diagnosis was proved microscopically, but the neck glands were not involved. Three-fifths of the lip was removed, including an adequate border of uninvolved tissue. The lip was reconstructed at the same operation, utilizing cheek, chin, and neck. Time indicates that he is cured of the neoplasm and the repair is satisfactory functionally and cosmetically. The patient's "company insurance" has offered twenty-five dollars to settle his surgical obligation. Another policy magnanimously offers five dollars. The latter states, in fine print after naming two or three standard operations, "all other operations, five dollars."

Another patient, a woman in late middle age, suffered a rare complication following treatment of trigeminal neuralgia. Apparently due to trophic disturbances, she lost a large part of the skin and subcutaneous tissue of her right cheek, including the anterior bony wall of antrum, and most of right side of her nose. Restoration of this three-dimensional loss required five reconstructive operations. Local tissues of cheek and upper neck, plus full thickness free skin grafts from both ears, have replaced the loss without ugly or curious disfigurement or impairment of function. When the time finally came for final deliberations, the surgeon received a letter over the signature of the president of an insurance company

to which the patient's husband had paid premiums for many years. The president insisted that he know "the number of square inches of skin graft involved in this so-called restoration." Obviously he, in all his wisdom, unearthed an antiquated fee schedule referring to flat surface skin grafting, as in the case of burns. He was unimpressed by the fact that the client had received the benefit of a specialized department of surgery. The patient was offered the sum of thirty-five dollars in settlement, endorsement of the check for which would release the company from all relevant obligations. Further examples are superfluous, our point being that our profession is being exploited.

We agree that the present social and economic order indicates the need for prepaid medical, surgical, and hospital coverage. Our profession has endorsed and supported it and we want to see it succeed. Cooperative companies of sound financial structure and ethical intentions are serving a useful function and, with us, are waylaying governmental intervention. However, lesser companies who are exploiting our patients and ourselves as physicians have no right to put a price on the value of our services. When a fee schedule names a price for a certain operation, the implication is that the surgery is worth that and no more. Many patients conclude that a greater fee represents an overcharge. When we accept extraneous fixation of our fees without dispute, confirmation of the company-patient transaction is implied. We thereby seem to admit that our normal charges are high. We have aided a vicious circle which is playing into the hands of all insurance carriers, the bad among the good. It is our obligation to warn our patients and employers who are spending good money to procure health and accident coverage which is inadequate, if not fraudulent.

Our profession has talked more and more of public health education. A tangible measure of success is indicated on every hand by response of patients and public organizations. Obviously, we cannot limit our efforts to matters which are entirely concerned with the scientific aspects of medicine. We also owe our people intelligent guidance in relevant actuarial problems.

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Red Cross in March; Cancer in April

THIS IS Red Cross month. Next month, April, is Cancer month.

Right at this moment we can hear some reader thinking, "All right, so what—so what does it have to do with me? Every month has a tag of some kind on it now, and most of them involve a solicitation."

Yes, part of that is true; almost every month does have a tag, a charitable tag if you will, over and above the Community Chest or other type of "single fund" drive each autumn. But let's not miss the big point, the really big one. And that is that this, above all, is the American Way, the Voluntary Way.

The other day a prominent businessman of our acquaintance was addressing a group of volunteers and he pointed out how many times, in a fund campaign he was aiding, other businessmen would complain about the solicitation with the almost uniform question, "Why doesn't the City do this instead—this ought to be done out of City funds." And our friend noted that these are the same businessmen who froth at the mouth and grow purple with rage every time they read the newspaper account of a new city budget, or state, or federal, and whose screams crack the walls at income tax time. As don't we all?

The answer is easy, if we want to be honest about it; we all have a choice to make. We can practice our preachments, give generously to the well-established, well-managed voluntary campaigns like Red Cross this month and the Cancer Society next month and the others in later months, watching carefully that we do not "bite" on the fake drives. Or we can abandon the American Voluntary Way, tell the government to do all these things, and ask, yes ask, our official representatives in city, state, and national legislative bodies to increase our taxes!

Which shall it be?

1952 Is the Year of Decision

So says the Medical Society of New Jersey and in a recent membership news letter offers this comment:

Nothing is more repugnant to irresponsible people than inescapable responsibility, nothing more distasteful to the weakly vacillating than the necessity for strong and definite action.

This year upon which we are now entering is destined to prove, for all times, the character of the American people. In this year of Presidential election either we will demonstrate that we are a thoughtful, vigorous people of dedicated and lofty purpose, or we will reveal ourselves as muddle-minded and indifferent, ready to tolerate and even to assist the agencies of our deterioration and debasement.

For the preservation and continuance of our national life and character we are called upon in 1952 to act. We shall need all the best of wisdom and courage that good men can muster and God can give. If we cannot meet the challenge of these critical times, it may well be that we shall never know again the privilege of free choice. Should we this time fail as articulate, free men, we must be prepared henceforth to drag out our lives as voiceless slaves.

The members of the medical profession have a double duty, as doctors and as citizens, to do all that they can to influence public opinion and action in the interests of the common good. The question to be answered is not "What kind of medicine shall we have to practice in the America of tomorrow?"—but "What kind of America shall we have tomorrow to practice medicine in?" 1952 will in large part supply the answer.

A total war is being waged. Our adversaries are united, determined, devious, and relentless. Should they win, we, the citizens, will hereafter serve the government instead of having the government serve us.

Ours is still the power of free decision. This year we are called upon again to employ it. Shall history record that we exercised this privilege wisely and well in 1952, or will it report that we used it for the last time?

Correspondence

ANOTHER MESSAGE FROM ENGLAND

About once a year, one of us receives a letter from an English colleague. The friendship dates from association during the war. The doctor was born and reared in Edinburgh but now teaches in Newcastle-Upon-Tyne. He is a meticulous student, a keen observer, and magnificent teacher. His letters sum up highlights of the preceding year in England, commenting upon the rise and fall of socialized medicine. They report the true history of our profession in that country. We have published excerpts from his messages before. The following is a paragraph from his letter dated January 20, 1952:

We are now expecting to tighten our belts more and more in the coming days. What form the economics are going to take I don't know but the forecasts that one hears from time to time are not pleasant. Everything is rising in price to nearly double the 1945 value. Economics in government expenditure are likely to hit the Health Service and medicine is likely to enter an economic blizzard. This has already settled over dentistry and the golden age has passed. Now most dentists have little or no waiting list and incomes have dropped with a bang. The technicians are feeling the pinch very much indeed and in Newcastle fifty are unemployed, yet a year ago there was not one available and they could command almost any salary they cared to ask for, and with this shortage of work the government is talking about dilution with New Zealand-type dental nurses! The hospitals, in my opinion, have definitely been upgraded with equipment and furnishings since the Health Service started but this will stop with the cuts that seem to be in store. Private surgical practice has dwindled very considerably and makes a very small addition to the Health Service income now. Several nursing homes have closed down. One aspect of the Health Service that is a great pest is the vast number of committees that have been formed and I could spend most of my time attending committees either in connection with the university or the hospital.

We had hoped that news from abroad would brighten with each successive year but the contrary has been true—each message noticeably more grim. They wonder how their austerity can become more austere, but it does. When their belts approach the last hole, they bore another one and carry on. What will be the end, and where is it going to lead? Only the pages of recorded history will finally tell.

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"WHAT manner of people are we who will fight at the drop of a hat to prevent control from the outside, and submit blindly to the conquest of our lives from within?" **—Willard Moore.**

Original Articles

THE SEWAGE DISPOSAL PROBLEM IN UTAH*

KENNETH B. CASTLETON, M.D.
SALT LAKE CITY

This study was undertaken in an effort to obtain accurate information regarding the sewage disposal situation in this state. It would appear from the information below that it is one of the most urgent problems facing the people of this state today. Some of the facts listed are amazing, shocking and almost unbelievable. One would think that we are living in the dark ages. Very few people in the state, and even very few doctors, must have any real concept of this problem. Otherwise measures would have been taken long ago to correct the situation.

There are at present seventy-nine towns in Utah with sewer collection systems serving 385,000 people. The remainder of the population (a total population of about 680,000) have no sewer systems and are forced to rely on septic tanks, cesspools, etc. Of these seventy-nine towns, only six, representing a little over 1 per cent of the entire population and about 2 per cent of the sewered population, provide complete treatment (primary and secondary), forty towns provide primary treatment and thirty-three towns provide no treatment at all. Those providing complete treatment are Dragerton, Sunnydale, Horse Canyon, Bacchus, Nephi and Royal. Of the forty towns which provide primary treatment, representing 17 per cent of the sewered population and around 9 per cent of the total population, twenty-eight use septic tanks, nine use Imhoff tanks, two use Clarigesters, and one primary settling tank with separate sludge digestion. It should be pointed out, however, that septic tanks are not primary units, since the effluent is devoid of dissolved oxygen and contains considerable organic matter. The thirty-three towns which provide no treatment at all include the larger cities of the state—Salt Lake, Ogden, Provo and Logan, and represent 81 per cent of the sewered population of the state, and about 60 per cent of the total population.

Let us now look at this problem from a geographical standpoint. Utah is unique geographically. There are three principal drainage basins—the Great Salt Lake Basin, the Sevier River Basin and the Colorado River Basin. The first two are closed basins in that they terminate in the Great Salt Lake and Sevier Lake, respectively. The Colorado River Basin is part of a large drainage system which empties into the Pacific Ocean. Of the total state popution of 680,000, 83 per cent reside in the Great Salt Lake Basin, 8 per cent in the Sevier River Basin, and 9 per cent in the Colorado River Basin. Examining each of these basins separately, we find that in the Great Salt Lake Basin the population is almost entirely restricted to the eastern shore line of Utah Lake and Great Salt Lake, the west side being largely desert in nature. These two lakes provide a convenient and natural outlet for sewage in this basin. Virtually all of the towns adjoining the lakes discharge their sewage into them. Among the towns utilizing the Great Salt Lake for this purpose are Salt Lake City, Garfield, Magna, Bountiful, Farmington, Kaysville, Layton, Syracuse, Clearfield, West Point, Clinton, Roy, Sunset, Ogden and Brigham City. The cities utilizing Utah Lake for this purpose include Payson, Springville, Spanish Fork, Provo and Orem. The sewage from many other towns of the Great Salt Lake Basin is discharged into canals, the Jordan River and other natural drainage channels. In other cases cesspools and septic tanks, etc., are

*A study by and on behalf of the Public Health Committee, Utah State Medical Association, with the assistance and approval of the Utah State Board of Health.

used. In most cases these municipal sewer outlets are located some distance from the lakes, the sewage being carried by open ditches to the lake. These ditches pass through agricultural sections and, according to the Utah State Board of Health, raw sewage has been used for irrigation purposes to irrigate fruits, vegetables, hay, grain and other farm products for human consumption.

Utah Lake is heavily polluted. Not only does it receive raw sewage from the towns as noted above, but it also receives large amounts of waste water (20 to 40 cu. ft. per second) from Geneva and Ironton Steel plants, containing coke, coal, oil and by-products of these plants. The lake is used primarily as a fresh water reservoir for supplying irrigation water to the valley between Utah Lake and Great Salt Lake. This water is used without any treatment whatever to irrigate a wide variety of crops and home gardens. Although the lake itself serves as an apparently effective secondary treatment facility, the addition of raw sewage along the entire route of the Jordan River, including the sewage from Murray, Midvale, Sandy and many other communities, results in heavy contamination. Utah Lake and the Jordan River are also used for swimming (although this has been condemned), boating, fishing and hunting. In all fairness to Geneva Steel Company, however, it should be added that it has made efforts in recent months to correct the polluting effect of its waste flow. To quote from a public health service memorandum report by Mr. Hayse Black, dated June 1, 1951: "Indications are that wastes from the (Geneva) steel plant may approach the minimum that can be accomplished by a systematic control within the plant supplemented by gravity separation of settleable solids and oil."

Great Salt Lake is also heavily polluted, principally by the raw, untreated sewage from Salt Lake City, but also from the contaminated Jordan River water, and by raw sewage from all of the towns on the esat shore, as noted above. The bactericidal and bacteriostatic powers of the concentrated salt solution is a matter of some uncertainty. Some studies which have been done in the past would seem to indicate that it has rather high bactericidal power and it is said that it is difficult to obtain positive cultures on ordinary media such as agar plates. Other studies, however, have indicated that a great variety of organisms are present in the water. It would seem that further carefully conducted investigations might well be carried out in this field as a public health project. Regardless of the antiseptic powers of the water, however, there still remain definite health threats in connection with the lake and sewage. It has been suggested, for example, that heavy brine does not mix readily with fresh water and therefore that at sewage outlets the heavily contaminated fresh water may float on top of the salt water for long periods of time and, hence, constitute a health hazard. Then, too, it is definitely known that many birds, especially ducks, geese, seagulls, etc., feed on the raw sewage in the canals leading to the lake and in the marshes around the lake, and that these must carry contamination in their flight elsewhere, and also into the homes of hunters. Likewise, muskrats and fish which are caught must be grossly contaminated. Mosquitoes, gnats and flies around the marshes are probably carried by winds to cities and towns in this vicinity, especially Salt Lake City.

In addition, the lake is used extensively for bathing and to a lesser degree for boating. Although a dike has been built recently from the eastern shore to Antelope Island so that sewage from Salt Lake and Davis Counties enters the lake north of it, the bathing beaches on the south shore are still contaminated to a considerable degree by the raw sewage from Garfield and Magna which empties into the lake just south of Saltair. The beaches are also contaminated by sewage from the bath houses at the beaches. Incidentally, an open ditch from the industrial center (old Remington Arms Plant) where there is a primary treatment plant, carries incompletely treated sewage to the lake and joins the latter very near a large salt plant where salt is recovered commercially by evaporation.

The Salt Lake City sewer system delivers its sewage partially by gravity and partially by pumping to the northwest section of the city where it becomes an open ditch, filthy, foul, blackish and bubbling. It continues as an open ditch out to the Great Salt Lake without emptying into the Jordan River as many people seem to believe. Water from this sewage canal has been known to be used in irrigation of truck gardens and other crops in this area.

The Sevier River Basin likewise uses the Sevier River to receive its sewage, usually without treatment. Again, the river is used heavily (in fact, virtually entirely) for irrigation purposes and this heavily polluted water is used to water such crops as fruits, grain, sugar beets, potatoes and other vegetables. There is some fishing, hunting and boating on the river and its reservoirs with the usual hazard that accompanies such activities in polluted water. Towns not located on streams discharge their sewage into canals with the same result and again, in many instances, open ditches convey the untreated sewage to the rivers and canals.

In the Colorado River Basin the situation is quite similar. Towns are built along the streams and sewage is placed directly into them. On smaller streams there is at times no dilution at all during the summer when the streams are low and the diversion upstream for irrigation purposes is heavy. Most of the sewage in this basin is used for irrigation purposes either diluted or straight, and, again, a great variety of food crops are being irrigated with this contaminated water. There are some instances in this state where municipalities get their domestic water supply from the polluted streams. This is true in the cases of Green River, Kenilworth and Castle Gate. No such condition obtains in the Great Salt Lake Basin at present, although water from the Deer Creek Reservoir will soon be passing to Salt Lake City, and the water of Deer Creek Reservoir is polluted by raw sewage from Heber City, and possibly from individual sources in the surrounding territory. There are also plans at present to provide culinary water for towns of Weber and Davis Counties from Weber River water, which is polluted by drainage from barnyards and agricultural lands and domestic sewage discharges.

This then gives a brief picture of the sewage situation in Utah. There are many unsolved problems pertaining to it, and there are many factors of our problem which are unique to this community. For example, in most states irrigation is not done and because of this a stream polluted by sewage is not used for the irrigation of fruits, vegetables, grains, etc. Likewise, we have much less water here than in most places and therefore our sewage is likely to be less diluted and the temptation to use polluted water more acute. It appears, however, that we are definitely backward in regard to legislation controlling water pollution, sewage disposal, etc. California, Oregon and Colorado have each enacted legislation in an effort to curb water pollution and the irrigation of food crops with sewage polluted waters. It is not definitely known how much danger there is to the use of polluted irrigation water. The extent of the hazard of contaminated migratory birds, especially ducks, and also contaminated insects such as flies and mosquitoes, is not known. There would seem to be a fertile field of investigation in the Great Salt Lake so far as its antiseptic properties are concerned, including bacteriologic studies, and the study of surface water contamination vs. deep water contamination, etc. Swimming, boating and fishing in contaminated waters must carry a certain hazard but no one knows how much. Then there is the problem of E.Coli contamination of culinaray water (although this is more intimately connected with the problem of drinking water than with sewage disposal). How much of the E.Coli contamination is due to human excreta, and how much is due to excreta from cattle, horses, deer, birds and other animals? As yet there is no known method of determining this, and we have no practical method as yet of determining the virus content of the water, either as to type or amount of virus. If the E.Coli content is high, does it indicate a heavy pollution with the viruses as well, and conversely, if

the E.Coli count is low, does it mean there is little virus content to the water? To state a practical example of this problem—if, as is claimed, the Deer Creek water as it leaves the dam has a low E.Coli count in spite of a heavy contamination with sewage when the water enters the reservoir, are we safe in assuming that this water, which will be used for drinking purposes, is free or relatively so from the potent viruses of hepatitis and poliomyelitis? It would seem that there is a tremendous field for investigative work in this respect.

Lastly, what can we do about correcting these great deficiencies in our public health matters? A National Stream Pollution Bill has been passed by Congress which provides for a study on stream pollution throughout the nation. Our local State Health Department is making such a survey here and has completed the survey of the Weber River drainage. The Federal Government has made funds available on a loan basis for the preparation of plans for sewage disposal plants and so far nineteen towns in Utah have applied for funds on that basis. The greatest need, however, is to arouse the population of this state to the conditions as they exist, and it would appear that the medical profession might well take the lead in initiating an educational program, first among our own profession and then among the general population. It seems highly probable that if the people were fully informed it would not take long to get some action. It should be pointed out, however, that the problem of sewage disposal is not a problem for individual cities. Rather it is a metropolitan problem. It would not solve the Salt Lake City problem, for example, if Salt Lake City put in complete sewage disposal facilities and the surrounding towns did not.

In summary, the sewage disposal facilities in this state are in a deplorable condition. For only about 1 per cent of the population is sewage treatment adequate. Grossly polluted water is used to irrigate fruit, vegetables, grains, and, in fact, a great variety of crops. In some cases this sewage is rather well diluted but in other cases the dilution is virtually nil. Ducks and geese which are heavily polluted are brought into our homes, and hunters, fishermen, swimmers and boaters are heavily contaminated with untreated sewage. Flies, mosquitoes and other insects undoubtedly carry sewage on their legs and bodies. Even some drinking water is polluted with raw sewage and it appears that before long this condition will become more prevalent. Although there are many problems unanswered, and much investigative work to be done, it appears clear that the need for adequate sewage disposal facilities in this state is extremely urgent, and that our laws are badly in need of revision. It might be well for us to encourage research into some of these problems by the U. S. Public Health Service, the University of Utah and possibly other agencies.

ANNUAL CLINICAL CONFERENCE, CHICAGO MEDICAL SOCIETY

The Clinical Conference which has been established by the Chicago Medical Society for presentation each spring, offers lectures on many aspects of medicine to keep doctors abreast of the new things being developed from year to year. Each year the Society presents something of special interest to those attending. It will be held March 4, 5, 6, 7, 1952, in the Palmer House, Chicago.

The year 1952 will show in response to popular demand, an increased number of demonstrations or work-shop periods in addition to the regular series of lectures. These demonstrations include presentation of patients, carefully selected scientific movies, and other features interesting from an educational standpoint. The lectures are on subjects of interest to both the general practitioner and the specialist and will be one-half hour in duration. The faculty, which is now being assembled, will represent outstanding teachers of the medical world.

The scientific and technical exhibits are being selected with great care. The scientific exhibits will represent visually some of the most recent advances in medicine. The technical exhibits are both helpful and time-saving and worthy of real study. To those who have attended previous clinical conferences, the wealth of material is well known.

For newcomers to this activity of a great medical center, it will be an opportunity to renew old acquaintances as well as improving one's medical outlook. The Chicago Medical Society Clinical Conference should be marked on every physician's calendar right now. The completed program will be available shortly and will be printed in our Bulletin or mailed upon request. This meeting has earned the reputation of being one of the most outstanding medical conferences in the country.

MUNICIPAL WATER SUPPLIES OF UTAH*

MICHAEL E. MURPHY, M.D.
SALT LAKE CITY

The procurement for its members of a satisfactory culinary water supply in the colonial period of any community is a relatively simple matter. The drainage areas of surface and underground waters being uncontaminated, merely tapping of a quantitatively adequate source and distribution of it is necessary. Contamination of the initially satisfactory supply, however, begins soon, concomitant with an increase in population, industrialization, the often unsanitary disposal of sewage and the dispersal of recreational activities to the watershed areas. Constant vigilance and increasingly complicated and expensive raw water treatment facilities to counterbalance the actual and potential contamination of the water supply become necessary.

An example of such an evolution in the problem of supply of a potable water has occurred in the case of Salt Lake City which initially had a safe, though untreated, water supply in its canyon streams, its springs and drilled wells. Later, with improper sewage disposal from communities and dwellings along the drainage sites, contamination through grazing activities, and increasing use of the watersheds as recreational areas, chlorination became necessary to insure the safety of the distributed water. Now, with even higher actual and potential pollution of its water sources, Salt Lake City is being forced to consider coagulation and filtration processes which, of course, involve considerably more in the way of equipment and expense than did previously adequate treatment.

Problems of water supply peculiar to arid portions of the West exist throughout most of Utah. Seldom is there available a single source of supply which meets the entire demand of any sizable community. In many instances municipal water rights in any single source must take into consideration the water rights of irrigational water-users. The multiplicity and dispersal of raw water sources necessarily complicates treatment. Also in many parts of the state the watershed areas are the only green and desirable recreational areas available. Recreational use of the watersheds leads to unpredictable and always possibly dangerous degrees of contamination. In spite of even the most successful sanitation measures in these recreational areas, and in spite of even the widest policing and dissemination of information as to the necessity of maintaining a suitable raw water supply, it seems unlikely that these measures, though desirable, can ever be depended upon to in any degree assure a uniformly safe source of supply. Rather, reliance must be placed on water treatment plants which provide an adequate margin of safety to overbalance the potential contamination from all these sources. However, to provide such a margin of safety often necessitates what appears to be an excessively expensive plant and too numerous operators to those who are in charge of municipal finances. Such is the case of Salt Lake City which recently commissioned a water supply survey board to review the status of its water as to supply and treatment. In general, the data which this board submitted indicated that although the water treatment facilities in use and to be constructed were adequate to control the actual present contamination they provided no margin of safety for the potential contamination. For some reason, probably the financial, they denied the significance of their data and made recommendations which took no cognizance of the potential hazard. In connection with placing reliance on sanitary measures and the policing of recreational activities in watershed areas there is always to be considered the factor of resentment by the public to what they feel is infringement upon their rightful recreational privileges by too much regimentation.

General misconceptions as to the purity of raw water and what constitutes adequate treatment have hindered the develop-

*A study by and on behalf of the Public Health Committee, Utah State Medical Association, with the assistance and approval of the Utah State Board of Health.

ment of proper treatment facilities in many communities. This general absence of information regarding the qualities of a safe water supply is reflected in the lack of any law in Utah making it mandatory that a water supply meet drinking water standards as set up by the United States Public Health Service. The fact that many Utah communities receive their supply from mountain streams and from springs and that these sources in the public mind are held to be of superior quality probably contributes a great deal to the general lack of concern as to the true state of the culinary water. Actually the only manner in which the influence on the bacterial count of such processes as storage or passage along a stream can be measured is by the bacteriological examination of properly collected samples from appropriate sites.

The Utah State Board of Health has, apparently, sufficient facilities for the bacteriologic examination of water, both raw and treated, to serve all these communities which lack such facilities. The problem is not, however, one of inadequate facilities but rather one of interest in or knowledge of the necessity for a bacteriologically acceptable water supply.

The sanitation division of the State Board of Health is at present engaged in a program of education of responsible individuals in any community as to the necessity for and means of obtaining a bacteriologically safe drinking water. In the past considerable resentment among those in charge and temporary near-hysteria among the populace of various communities has been aroused by blunt publication of the fact that the local water supply was unsafe; seldom was any concrete improvement brought about by this measure. The program of the State Board of Health is now one which seeks local cooperation and consists of two phases: 1. Encouragement of all communities to submit adequate samples for bacteriological examination, the results of which are not made public. 2. A water source and treatment survey service.

Facilities for bacteriologic examination, as previously stated, are adequate but the survey service is hampered by lack of finances and insufficient personnel. At present three consultants are engaged in evaluating existing treatment facilities and acting in an advisory capacity in the erection of new plants, while one man provides information as to the suitability of raw water sources. Two of these men are soon leaving for more lucrative positions.

A survey of the water supply of one hundred communities has thus far in two years been accomplished and the responsible local individuals contacted. In about 50 per cent of instances a beginning on the suggested improvements has been made by the community. Anyone wishing to check surveys, recommendations, or local accomplishments may review the records at the State Health Department or request reports from the communities concerned.

Bacteriological data on the water supply of almost every community which has availed itself of the service is incomplete due to the failure to submit what is considered an adequate sampling by United States Public Health standards. Such information as is available indicates that in somewhat over 50 per cent of Utah municipalities the water supply is unsafe for drinking purposes.

The Utah State Public Health Service in conjunction with the university holds annually a group of seminars on water purification for interested individuals. The idea seems commendable but their mode of acquainting interested persons with the existence of such a source of information seems inadequate as one learns of it only by chance.

The following data as to water sources and treatment were obtained in a recent survey of 288 Utah municipalities:

TREATMENT

1. None	230
2. Settling	8
3. Chlorination	37
4. Settling and chlorination	5
5. Settling and aeration	1
6. Complete treatment	5

SOURCE AND TREATMENT

1. Springs	
None	192
Settling	1
Chlorination	6
Settling and aeration	1

2. Wells	
None	21
Settling	1
Chlorination	3
3. Wells and springs	
None	9
Chlorination	2
4. Streams	
None	9
Settling	4
Chlorination	4
Settling and chlorination	1
Complete treatment	3
5. Streams, wells and springs	
None	7
Chlorination	15
Settling and chlorination	1
6. Mine shafts and wells or springs	
None	7
Chlorination	1
7. Canal	
None	2
Settling	2
Chlorination	3
Settling and chlorination	2
Complete treatment	2

The fact that even adequate treatment facilities exist does not necessarily insure a safe water supply. The proper function of any water-treatment plant depends in large part upon the intelligence and the integrity of the operators. A visit to the Salt Lake City treatment plants impresses one with the necessity for trained operators on constant duty and the even greater desirability of more automatic type equipment.

Further, the relationship of the water supply of any community to not only its own sewage disposal but to that of adjacent communities is an important one and is being discussed by Dr. Castleton. An example of the possible result of improper sewage disposal supervision within a community is the outbreak of amebic dysentery in Chicago in 1933 which was caused by technical errors in the piping of water and sewage within a single hotel. Chicago is a city which has a single, entirely safe source of water from far out in Lake Michigan. The water is chlorinated only to guard against contamination during its distribution throughout the city but even this proved inadequate under these circumstances. Salt Lake City, which in the near future shall obtain a large part of its drinking water supply from the Deer Creek Reservoir, shall have to press for satisfactory sewage disposal in those communities where sewage drains into the watersheds entering the reservoir. At present because of lack of proper sewage disposal facilities in these communities and a lack of facilities for complete treatment of the Deer Creek Reservoir water in Salt Lake City, reliance shall have to be placed on natural purification processes during storage and subsequent chlorination.

CURARE IN THYROID SURGERY*

A PRELIMINARY REPORT

E. H. DELLINGER, M.D.
LAS VEGAS, NEW MEXICO

Since curare is established as a safe and useful drug, under properly controlled conditions, I wish to offer an entirely new concept of its usefulness in all three phases of thyroid surgery. We have, so far, not many cases to offer, but the action is so definite, predictable and physiologically sound, that I wish to present a description of our method of use and results. Up to this time curare has been used in a multitude of cases for relaxation with general and local anesthesia with gratifying results; but I have not found any reported cases of its use as an adjunct to local novacain anesthesia in thyroid surgery, nor in pre-operative preparation or postoperative treatment.

In all the cases I have been able to review, the medication has been given only during the operative period and used intravenously with local anesthesia. We were able to get good relaxation with its use intravenously but the effect was much less in thirty or forty minutes after its use. Having used the drug intra-muscularly at eight-hour intervals in many orthopedic and some polio cases, we tried giving it intra-

*Intercostrin (Squibb) was used throughout, because it was first used and we felt it would be less confusing to continue with the one preparation. Credit is due Dr. Max Thorek for review and advice and Dr. W. R. Lovelace for use of his library.

muscularly for three pre-operative days in small doses to get the amount regulated to reasonable relaxation without much respiratory depression. As noted by many research workers, the neck muscles are the first to be relaxed and response is more profound in this group of muscles than others, so a small dosage could be expected to give the desired result. Hence we use from .3 to .8 c.c. of Intercostrin at 2 p.m., 10 p.m. and 6 a.m. for three or more pre-operative days. We have hospitalized the patient for seven days previous to operation and do a BMR on admission and on the day before operation. As soon as curare was given pre-operatively we noted a much greater drop in the basal rate than we had been seeing with regular bed rest, iodine and propylthiouracil. The answer was immediately recognized, when we considered the action—that is, cutting down the nerve-to-muscle communication, thereby slowing down muscular metabolism throughout the body. Having a sound physiological reason for this slowed metabolism, we felt that the same reaction could be expected and desired following operation. So we have been using it in our later cases for three to five days postoperatively, with the gratifying result of a very quiet and almost afebrile post-operative course.

Here I will quote the figures of our two latest cases and will give complete case tables of all our cases in the next report:

Mr. B., aged 47, under medical treatment for fourteen months with continued basal rate from +65 to 78. BMR on admission +65, weight 135; five days later with .5 c.c. Intercostrin every eight hours, rate was +22. Operated on sixth day, Intercostrin continued without interruption. Temperature did not rise above 101.2 BMR fifth postoperative day, +11; two months later, +6; weight, 152 pounds.

Mrs. S., aged 41, weight, 84 pounds. Two months before admission BMR +62, on admission +70; .3 c.c. Intercostrin, intramuscularly every eight hours, four days BMR +25; three days postoperative +12; postoperative temperature did not exceed 100.2.

These are unusual drops in BMR until we began using curare; but in each of our cases under this management there has been a drop in BMR from 45 to 60 per cent in three to six days of pre-operative preparation with curare. Also postoperatively there has been no approach to thyroid crisis. With only twenty-eight cases to date it is much too soon to answer many of the questions that arise. However, if the present trend continues, it will give a very definite and dependable method of reducing the metabolic rate to a safe operative level in a short time. There is also the added advantage of maintaining a lowered rate through the critical postoperative period.

Our preparation follows the accepted routine as outlined in the June, 1949, Journal of International Colleges, with these two additions: 1, E.C.G. and 2, voice recording before and two weeks after.

Feeling as I do, that the high metabolic rate is a chemical over-stimulation, I feel justified in using the chemical block of curare to lessen muscular activity with resultant lowering of metabolism, accompanied by a slower heart rate and more complete rest for the patient.

By the time this series has reached fifty cases, we will give tabular reports and rechecks and will also have a number of cases to report such as fracture cases with BMR on admission and seven days later, and goitre cases on rest with curare and BMR following without surgery.

Conclusion

We are offering a new adaptation of a standardized drug which we believe shortens the pre-operative preparation period and lessens the operative risk, makes the operative procedure under local anesthetic easier, makes the postoperative course much less eventful, especially in critical cases. Thus it makes the operation easier on the patient with less attendant danger to the prcoedure.

CLINICAL OPHTHALMOLOGY CONFERENCE

The Stanford University School of Medicine will offer the annual postgraduate conference in Clinical Ophthalmology from March 24 through 28, 1952. The program this year will be devoted to Ophthalmic Surgery. Registration will be open to physicians who limit their practice to the treatment of diseases of the eye, ear, nose, and throat. In order to allow free discussion by members of the conference, registration will be limited to thirty physicians.

Instructors will be Dr. A. Edward Maumenee, Dr. Dohrmann K. Pischel, Dr. Jerome W. Bettman, Dr. Max Fine, Dr. Earle H. McBain, and Dr. Arthur J. Jampolsky.

Programs and further information may be obtained from Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

VASCULAR AND PIGMENTED NEVI*

DOUGLAS W. MACOMBER, M.D.
DENVER

A brief and practical consideration of nevi should omit the rarer types, such as those originating from fat, subcutaneous, nerve and glandular tissues. Thus the usual classification is divided into two important groups, vascular and pigmented.

The literature contains papers by colleagues interested in this field for many years, chiefly dermatologists and radiologists, rarely surgeons. Most articles comment upon every phase of the problem except surgical treatment or dismiss surgery without weighing its merits. For example, a paragraph referring to vascular nevi states: "No treatment is so successful as leaving them alone . . . Any treatment results in scar and scar leads to embarrassing medicolegal complications . . . Surgery is preferred by surgeons." Perhaps his conclusions were drawn from observations of results following destruction in situ, especially before limitations were clarified.

When a tumor does not endanger life or health but is chiefly a cosmetic problem, treatment is justified only if the patient may be offered a lesser defect. The patient who merely exchanges one defect for another equally objectionable is not satisfied and is not proud of his doctor or the treatment. Residual "tracks" from previous treatment include hypertrophied scars; keloids; blanched or mottled, unsubstantial and sensitive spots; pits; dermatoses; atrophic or maldeveloped tissues; ulcers; squamous and basal cell cancers. They constitute adequate evidence that our profession has failed thus far to perfect ideal answers to the problem. Thus, those of us who deal with skin tumors should pool our respective knowledge and resources; there could be no better opportunity for cooperation of the specialists. No one of us has all the answers; often more than one method will work out to the patient's benefit. Let us decide what treatment most decisively removes the abnormal tissue and leaves the minimum residual defect. If a skin graft, including the scar which inevitably surrounds it, provides a better appearing, more durable, and more comfortable covering than that which follows destruction in situ, let us provide it. If a linear scar is of better appearance than a skin graft or than a raised, depressed, or stellate scar, the patient should have its advantage. Patients abhor glances and questions elicted by defects which are unusual. However, linear scars are so common that they are not curious to the average observer, and local tissues are always superior in color and quality. But if the physical agents can destroy or instigate absorption of the tumor without scar or with minimum scar, such should be the method of choice.

*Based upon a presentation before the Western Slope Spring Clinics of 1950, Grand Junction, Colo.

Vascular Nevi

Vascular nevi are generally classified as flat (strawberry marks, port-wine stains); raised (usually red or purple, warty or pedunculated); deep or cavernous (with or without superficial discoloration). Some of these marks remain essentially the same size despite normal growth of the individual; some grow in proportion to natural growth; others grow more rapidly than the individual. Some of the latter appear to creep into adjacent tissues like a tiny prairie fire. Occasionally some new satellites appear in adjacent skin. Mitotic figures may be demonstrated within some of them and pathologists state these growths are locally malignant. They are occasionally classified among the endotheliomata and should be removed or destroyed early. Temporization may be advisable otherwise. A certain proportion, perhaps as many as one-third of the smaller lesions, may disappear spontaneously. If they have not done so by the age of five years, they probably will not. After time has demonstrated that the tumor is not regressing and it is functionally or cosmetically objectionable, appropriate therapy is indicated. The treatment which is most effective and is followed by the

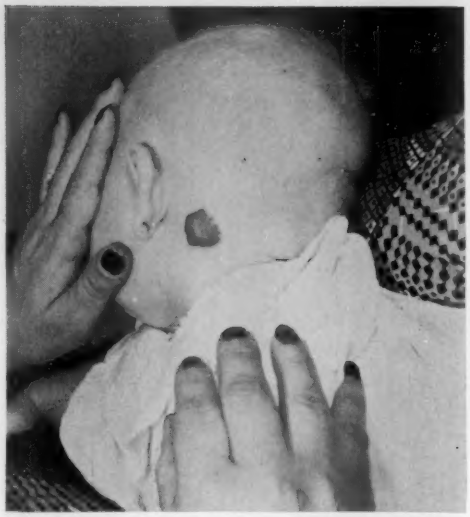


Fig. 1. Red or purple hemangiomata are not rare in infants. A significant per cent regress unless they grow more rapidly than the child, or unless they bulge upon crying or straining.

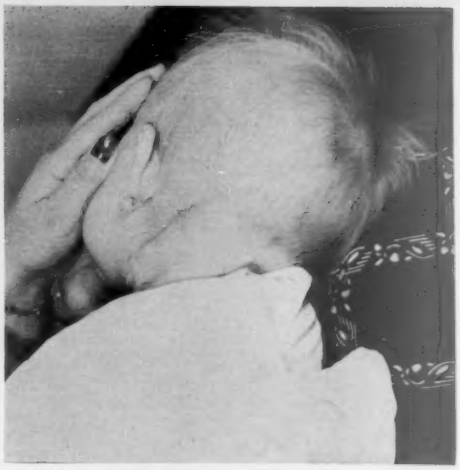


Fig. 2. Excision, wide local undermining, and direct closure disposes of the tumor promptly. Photo three weeks after surgery.

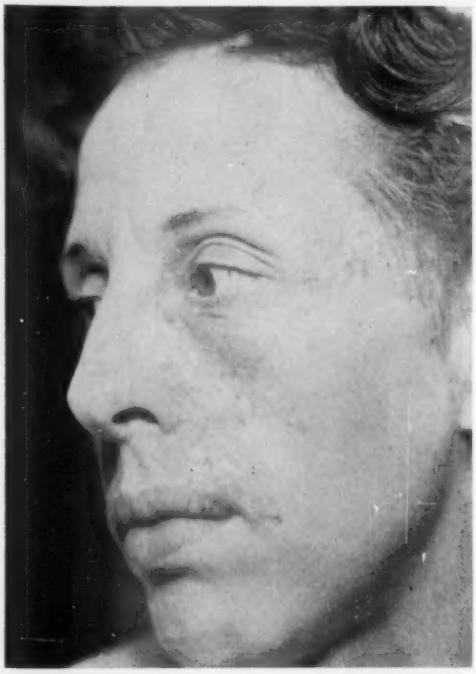


Fig. 3. Capillary hemangioma (strawberry mark; port wine stain) partially destroyed by physical agents during childhood.

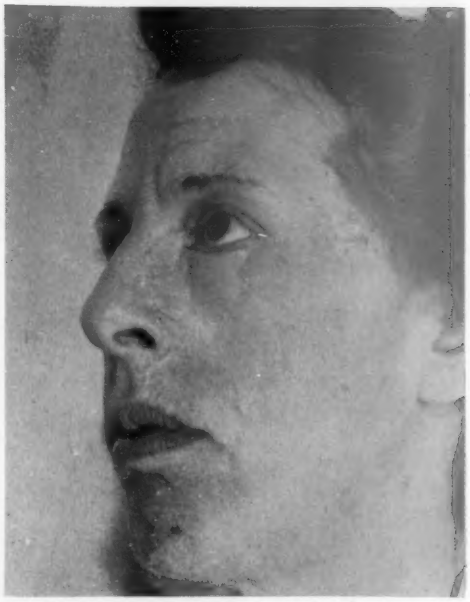


Fig. 4. Tumor was excised in stages and thick split skin grafts applied.

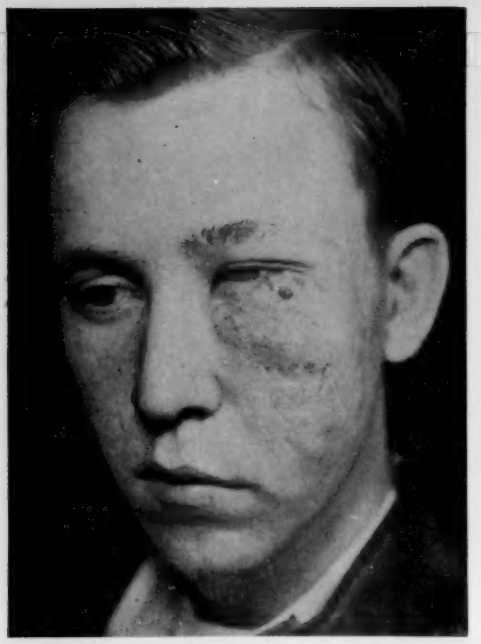


Fig. 5. Cavernous hemangioma with some superficial capillary elements.

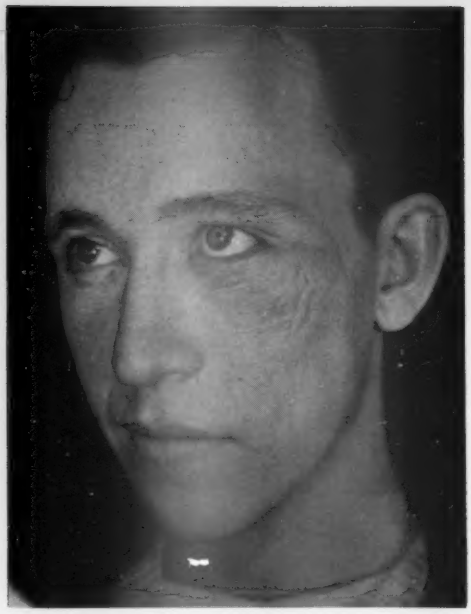


Fig. 6. Tumor was excised in one stage. Massive hemorrhage was neutralized by blood transfusions during operation.

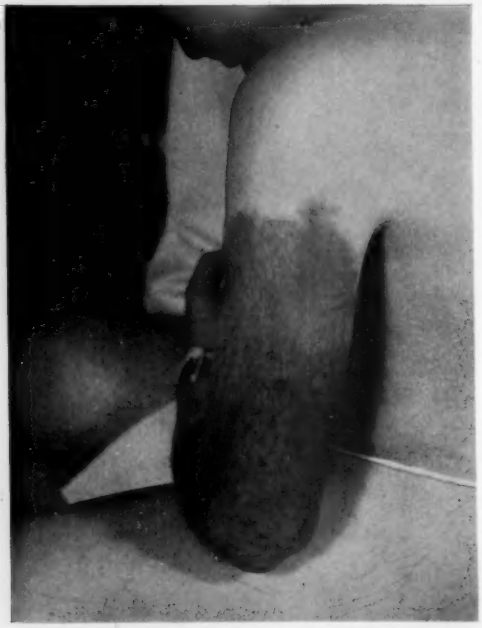


Fig 7 Pigmented hairy nevus involving upper arm and upper third of forearm.

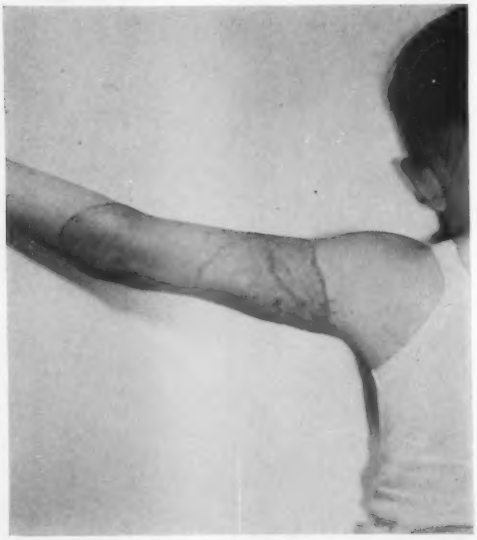


Fig. 8. Excision and skin grafting in one stage. Residual defect resembles a third degree burn grafted early—far more acceptable to the patient than a curious "birth mark."

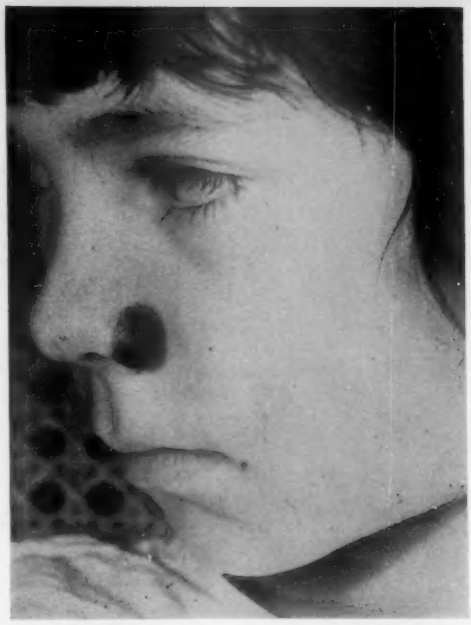


Fig. 9. Pigmented hairy nevus occupying ala of nose.

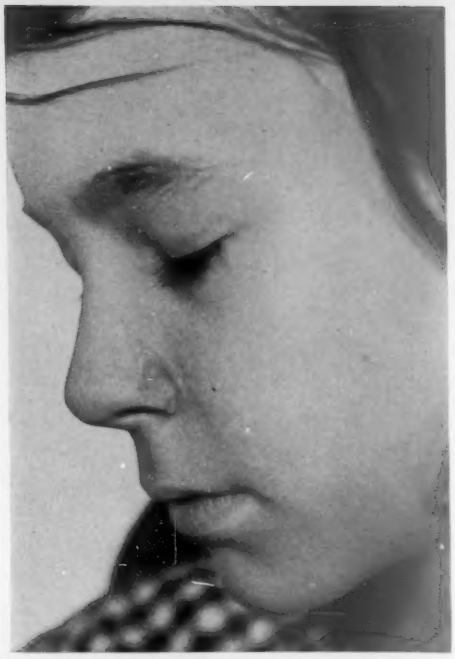


Fig. 10. After excision and application of full thickness free (Wolfe) graft from behind ear.

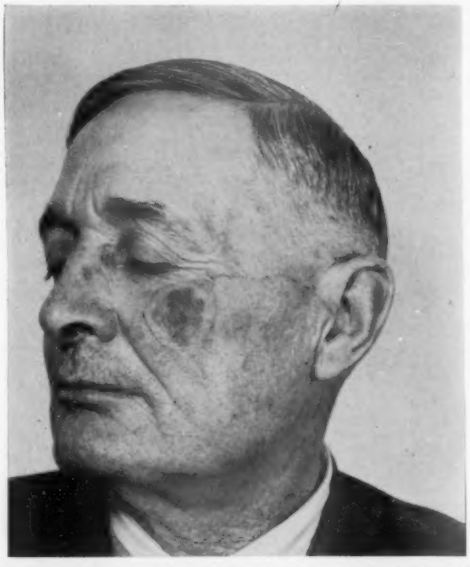


Fig. 11. In many locations nevi may be excised and wound closed at once with local tissues. This case presents a melanoma with typical history—small ordinary pigmented mole, present five years or more (probably more), traumatized about two years ago and has been enlarging ever since.

Fig. 12. Removal, including liberal margin of uninvolved tisses, and direct closure with local rotation skin flap—a superior match in color and quality of skin, as compared with remote free skin graft.

minimum residual defect should be chosen.

Tattooing vascular nevi with flesh colored pigments has given some encouragement. However, repeated treatments are required and partial recurrence is frequent. Color matching thus far is not perfect, resulting in an unnatural "china doll" appearance. Women still apply cosmetics, though tattooing may simplify the procedure. Men will not resort to this expedient and usually prefer a skin graft or scar which the average observer would dismiss as a burn or other accident. People shun stigmas generally implied by "birth marks" or other inherited abnormalities.

Pigmented Nevi

Recorded history and study of pigmented nevi demonstrates that amount of pigmentation is not a dependable index to danger of malignant changes and metastasis. Potential danger of the tumor is rather in proportion to any physical change which occurs in its structure. Spontaneous appearance, change in size, depth of pigmentation, thickness, or sensitiveness may appear to be instigated by trauma, conservative or inadequate treatment, and by growth propensities of the individual. Dangerous physical change is practically unheard of prior to puberty. The common pigmented mole or junction nevus which has its origin at the junction of the dermis and epidermis is the common precursor of malignant melanoma but, of course, relatively few ever undergo malignant changes.

How, then, shall we advise our patients? Removal of the growth should be advised if it shows physical change, if it is located in an area exposed to trauma, or if it is ugly, repulsive, or otherwise cosmetically or psychologically objectionable to the patient. "Watching" a threatening or dangerous pathologic change occur in the structure of a nevus is just as much to be condemned as the same passivity regarding cancer. Malignant melanoma is a spectacularly aggressive tumor capable of metastasis to any organ or tissue of the body. Early and adequate excision is positively indicated.

The Book Corner

New Books Received

The Battle for Mental Health: By James Clark Moloney, M.D. Copyright, 1952. Philosophical Library, New York.

Penicillin Decade: 1941-1951, Sensitizations and Toxicities: By Lawrence Weld Smith, M.D., Medical Director, Commercial Solvents Corporation. Ann Dolan Walker, R.N., former editor, "Trained Nurse and Hospital Review." Arundel Press Inc., Washington, D. C. Copyright, 1951.

Plastic Surgery of the Nose: Including Reconstruction of War Injuries and of Deformities From Neoplastic, Traumatic, Radiation, Congenital, and Other Causes: By James Barrett Brown, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Mo.; Chief Consultant in Plastic Surgery, United States Veterans' Administration, Washington, D. C.; formerly Senior Consultant in Plastic Surgery, United States Army and in E.T.O., and Chief of Plastic Surgery, Valley Forge General Hosptal. And Frank McDowell, M.D., Assistant Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Mo.; with 379 illustrations, including 48 in color. St. Lous, Mo., The C. V. Mosby Company, 1951.

Antibiotic Therapy: By Henry Welch, Ph.D., Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. And Charles N. Lewis, M.D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. Foreword by Chester S. Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine; Chairman, Committee on Medicine, and Chairman, Committee on Chemotherapy of the National Research Council. The Arundel Press, Inc., Washington, D. C.

The Rockefeller Foundation: International Health Division, Annual Report, 1950. 49 West 49th Street, New York.

Biological Antagonism: The Theory of Biological Relativity: By Gustav J. Martin, Sc.D., Research Director, The National Drug Company, Philadelphia. The Blakiston Company, New York, Toronto, Philadelphia, 1951.

The American Illustrated Medical Dictionary, A Complete Dictionary of the Terms Used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology and Medical Biography, With Their Pronunciation, Derivation and Definition: By W. A. Newman, Dorland, A.M., M.D., F.A.C.S., Lieutenant-Colonel, M.R.C., U. S. Army; former member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. Twenty-Second Edition, with 720 illustrations, including 48 plates. Philadelphia and London: W. B. Saunders Company, 1951.

Diagnosis and Treatment of Menstrual Disorders and Sterility: By Charles Mazer, M.S., F.A.C.S., formerly Associate Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Attending Gynecologist, St. Agnes Hospital; Consulting Gynecologist, Mount Sinai Hospital, Philadelphia; and S. Leon Israel, M.D., F.A.C.S., Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Attending Gynecologist, Mount Sinai Hospital, Pheladelphia. Third edition, revised with 137 illustrations. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York.

Your Diabetes: A Complete Manual for Patients: By Herbert Pollack, M.D., Associate Physician for Metabolic Diseases, Mount Sinai Hospital, New York; Marie V. Krause, M.S., Consulting Dietician; Revised Edition. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers.

MATERNAL and CHILD HEALTH

The comment following this case history represents the opinion of the Committee on Maternal and Child Health of the Colorado State Medical Society and is not the opinion of the Editors.

This patient is a 25-year-old, white, married, para 3, with one living child. Her EDC was February 29, 1950. Serologic test for syphilis was negative. Her Rh was negative and Rh antibodies were present in albumin—1:1024. The past obstetrical history is of importance because she was delivered by cesarean section in her first pregnancy. A year later, an ectopic gestation was removed from the right tube. During the operation, she received a transfusion of Rh positive blood. Three years later, she delivered, vaginally, a term-size stillborn infant, at which time she had hypertension and kidney trouble.

The patient was first seen for prenatal care in her present pregnancy on September 10, 1949. Her physical examination was essentially normal and her weight was 125 pounds. About September 24, 1949, the patient felt no fetal movements and on October 7, 1949, no fetal heart was recorded. She was first admitted to the hospital for study on October 28, 1949. All findings were normal except fetal death in utero and she was discharged in good condition, October 30, 1949. She was readmitted on November 11, 1949, because of acute toxemia of pregnancy. On vaginal examination, the cervix was long, thick and closed. An x-ray of the abdomen indicated fetal death in utero. On November 12, 1949, the second day after admission, the patient's general condition remained good. A sample of blood showed immediate clot formation. However, these clots were quite small and after one hour of incubation, disintegrated and almost disappeared. On the third day of admission, November 13, 1949, the patient first noted a small amount of vaginal bleeding. This was not accompanied by abdominal pain nor regular uterine contractions. She also developed rather large hematomata about the sites of needle punctures. Laboratory procedures, carried out at this time, showed the following: Prothrombin 37 per cent of normal; platelets 126,720; RBC 3,960,000; tourniquet test was positive showing 23 petechiae in a circle one and one-half centimeters in diameter; plasma-fibrinogen level was 50 milligrams per cent; and the cephalin flocculation test was two plus at 24 hours and three plus at 48 hours. The patient's blood pressure during the day varied from 176/122 to 120/80. By the evening of November 13, 1949, the patient's blood coagulation defect increased as evidenced by the clinical evaluation of clot dissolution. The abnormality was essentially a fibropenia. It was planned that when the blood coagulation defect had been corrected by fresh whole blood transfusions and by fibrinogen, pregnancy should be terminated. Cesaeran section was selected as the method of delivery because (1) of an unfavorable cervix, (2) pre-eclampsia and (3) a previous cesarean section. During the four hours prior to cesarean section, the patient was prepared with 500 c.c. of whole blood and 72 milligrams of Vitamin K, three grams of fibrinogen, intravenously, and then a classical cesarean section was done under cyclopropane anesthesia. The infant was macerated and weighed 800 grams. During and following operation, the patient was given 1500 c.c. of whole blood and one gram of fibrinogen. At the close of the operation, blood was present in the patient's nose, mouth and vagina. She continued to be dyspneic, cyanotic, unconscious and succumbed three hours after operation. The only positive autopsy findings were hemorrhage and edema of the lungs. Very little blood-clot formation could be found in any organ.

Summary

This case represents a maternal death due to shock and hemorrhage. The cause of hemorrhage was based primarily upon a coagulation defect in the blood; namely, fibrinopenia. This abnormality of the blood-clotting mechanism was in turn associated with intrauterine fetal death, Rh negativity with sensitization and pre-eclampsia. The terminal shock was believed due to cesarean section, cyclopropane anesthesia and insufficient replacement of fresh whole blood and fibrinogen. Maternal deaths attributable to hemorrhage and shock have not decreased dramatically during the past ten years. This is true in spite of the widespread availability of blood banks, donor lists, Rh-typing facilities and excellent prenatal care. It is probably true because as yet there are no substitutes for sound obstetrical judgment in the management of complicated bleeding patients.

This rather rare case of obstetric hemorrhage and shock is an example in point. This patient was known to be Rh negative and sensitized, was hospitalized in anticipation of a hemorrhage, had blood and fibrinogen available, but succumbed because of a hasty traumatic delivery, associated with a blood loss which was not adequately replaced.

Comment

During 1950, three similar cases of hemorrhage and shock, probably due to fibrinopenia, have been reported in the Rocky Mountain Area. This coagulation defect is usually associated with toxemia of pregnancy, abruptio placenta, and death in utero. It has been described in detail by Weiner, et al. (Am. J. Obst. & Gynec., 60:379, 1950) and is attributed to afibrinogenemia. Others suggest that its etiology depends on a circulating fibrinolysin or is the result of massive fibrin deposition (Schneider, SGO, 92:27, 1951). Whatever the cause may be, the practical implications suggested by this hemorrhagic death should center about diagnosis and treatment. Any patient who has abruptio placenta or fetal death in utero with Rh sensitization should be watched carefully for evidences of abnormal bleeding (ecchymoses, petechiae, bleeding from nose, gums, puncture sites and vagina). The diagnosis of fibrinopenia can be made by drawing a sample of the patient's blood and observing the absence of clot formation or the marked decrease in the size and stability of the clot after one hour's incubation. Certainly, before any definitive therapy is contemplated in a patient with fibrinopenia, one should make sure that the coagulation defect has been corrected by administration of adequate amounts of fresh whole blood and sufficient quantities of human fibrinogen (six grams of fibrinogen appears to be the correct total amount to give). It is exceedingly important that the correction of this bleeding defect be done prior to vaginal delivery, cesarean section, cesarean hysterectomy and especially any contemplated postpartum hysterectomy.

Organization

COLORADO
State Medical Society

Colorado Accepts The Challenge!

The American Medical Educational Foundation was established in 1950, under the sponsorship of the American Medical Association, in answer to the urgent appeal of the medical colleges of this country for much-needed financial assistance.

Recognizing the fundamental obligation on the part of organized medicine to support medical education, the A.M.A. in December, 1950, appropriated $500,000 for the Foundation as a nucleus for the funds to be raised by the medical profession in 1951.

Fund-raising campaigns were established among the various state and county societies with varying degrees of success. Some of the campaigns were very late in starting and in many cases the sums collected by the end of the year were not truly representative of the potentialities of the participating society. Nevertheless, $745,917 were contributed to the Foundation Fund in 1951, representing 1,811 individual physicians, thirty-three organizations, and thirty-three lay friends of the profession. Colorado stood high on this list, ninety-eight physicians and one organization contributing a total of $8,620.

Directors of the Foundation believe that a far greater and more representative response can be obtained in 1952. For this reason a meeting of State Representatives was held in Chicago February 17 to plan the 1952 Foundation Drive. Colorado was represented at this meeting by Dr. Atha Thomas, State Chairman of the A.M.A. Foundation Committee. At this meeting the responsibility of the medical profession to support this campaign to the fullest was reiterated and plans suggested for conducting the campaign on state and local society levels.

It was further pointed out that the ultimate success of the Foundation will largely depend upon the degree of interest and the effort put forth in its support by the state and county medical societies.

It was also emphasized that this must be a continuing effort extending over a period of years if the need eventually is to be met.

The Colorado State Medical Society has accepted this challenge and through the action of the Executive Committee of the Board of Trustees has empowered the A.M.A. Foundation Committee under the Chairmanship of Dr. Thomas to organize and conduct a Fund-Raising Campaign this spring through the component societies.

This committee will communicate with each component society in the near future. Every member is urged to do all in his power to cooperate in this enterprise, not only by a generous contribution but by extending enthusiastic support to the Foundation, thus demonstrating that the medical profession in Colorado can and will successfully meet this challenge.

OFFICIAL NOTICE

To All Members of the
Colorado State Medical Society:

Certain amendments to the "Rules of the Board of Supervisors of the Colorado State Medical Society" have been adopted by that Board and were on February 13, 1952, approved by the Board of Councilors of the Society.

Chapter VII, Section 12, of the By-Laws of the Colorado State Medical Society provides in part as follows: "The Board (of Supervisors) shall have power to adopt rules to govern matters within its jurisdiction, and said rules after approval by the Board of Councilors shall be published in the official Journal of the Society and shall be binding upon all members of the Society ten days after said publication."

In compliance with the above quoted section of the By-Laws, the complete Rules of the Board of Supervisors is herewith republished, including amendments approved February 13, 1952.

By Order of the Board of Councilors,

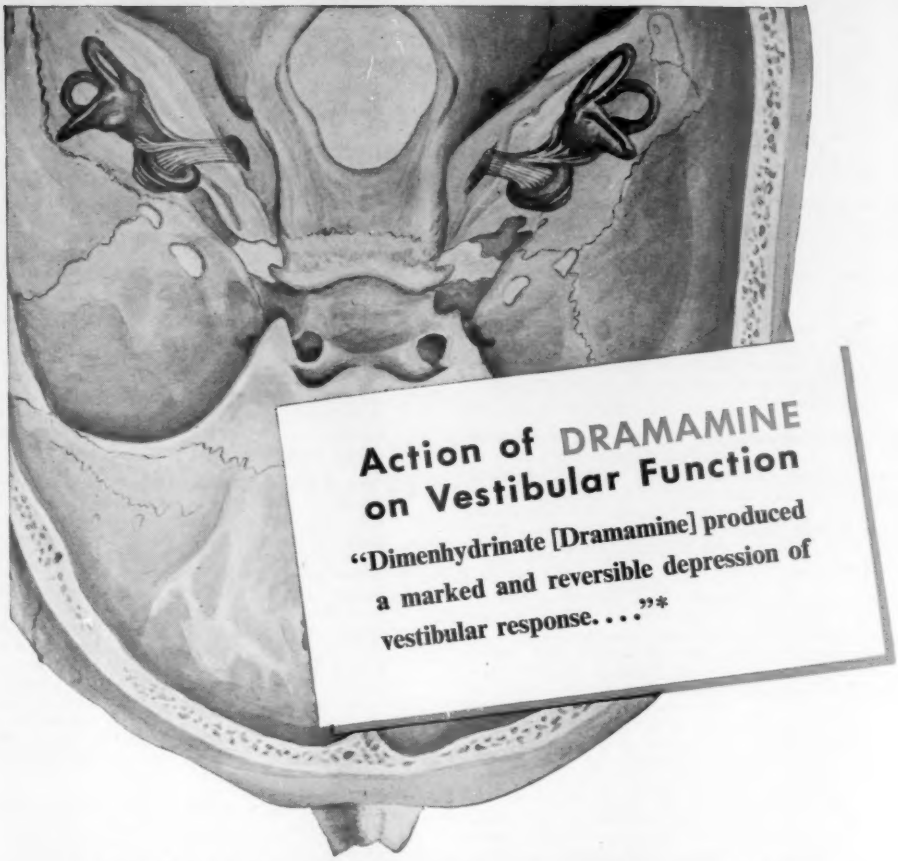
HARVEY T. SETHMAN,
Executive Secretary.

RULES OF THE BOARD OF SUPERVISORS
OF THE
COLORADO STATE MEDICAL SOCIETY

1. **PURPOSES OF THE BOARD:**
   a. To act as the Society's "grand jury" for investigating complaints and/or initiating investigations concerning professional conduct and ethical deportment. In furtherance of this purpose, this Board may require periodic reports from similar Boards or Committees organized by Component Societies.

   b. To prepare, for issuance to the entire membership in bulletin form through the executive office, periodic bulletins on ethical deportment containing definite educational advice to physicians in this regard.

   c. To initiate and prosecute, just as would a grand jury in civil procedures, charges against any physician deemed by the Board guilty of unprofessional conduct. These charges may, in the discretion and judgment of the Board, be filed originally with the Board of Censors of any component society, direct with the Councilor of the appropriate district of the State Society, direct with the Board of Councilors of the State Society, direct with the State Board of Medical Examiners, or direct with any



Action of DRAMAMINE on Vestibular Function

"Dimenhydrinate [Dramamine] produced a marked and reversible depression of vestibular response. . . ."*

In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milliamperage necessary to effect tilting."

The great effectiveness of Dramamine in motion sickness, they state, ". . . is probably related primarily to its ability to depress vestibular function. . . ."

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for prevention and treatment of motion sickness—

Now available in these dosage forms: { Tablets — 50 mg. / Liquid — 12 mg. per 4 cc. / Average dose — 50 mg.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE SEARLE

criminal court, according to the nature of the charges.

d. By way of further definition, it should be understood that the Board of Supervisors has no final jurisdiction in a judicial way. Just as would a grand jury, it will receive and pass its own judgment upon evidence, but it will not assume authority to discipline any physician. It may at any time express its advice to a member of the Society on any matter pertaining to professional conduct.

e. In pursuance of its function as a grand jury within the structure of the Society the Board shall have the power and authority to summon members of the Society to appear before it, either in connection with complaints involving the members summoned or as witnesses in cases involving other members. In case any member shall fail to respond to such summons, the Board of Supervisors shall cite the member before the Board of Councilors for contempt proceedings.

2. **Standards of conduct.** The current edition of the "Principles of Medical Ethics of the American Medical Association," as interpreted from time to time by the Board of Councilors of the Colorado State Medical Society for this state, shall be the final standard by which all professional conduct and ethical deportment are determined.

3. **Organization of Board.** The Board annually elects a chairman, a vice-chairman, and a secretary from among its own members. The By-Laws of the Society do not permit any member of the Board to participate in the deliberation of questions concerning the conduct of a physician residing in the jurisdiction of that Board member's component society. In view of this fact the Vice-Chairman will preside in all cases involving a member of the Chairman's district, and the Vice-Chairman will serve as Secretary in all cases involving a member of the Secretary's district. Thus, two disinterested officers of the board will always assume these functions. Any person against whom an accusation is made will be informed that the member of the Board residing in his district will not be present during the Board's deliberation of that case. However, if the accused is willing, the Acting Chairman of the Board may, on occasion, instruct the Board member in the accused's district to undertake preliminary investigation, obtain information, and report to the Board, in order to expedite proceedings and eliminate unnecessary travel.

4. **Limitation on Attendance; Professional and Technical Assistance:**

a. Except as provided for in these Rules, no person other than elected members of the Board and any witnesses then being heard will be admitted to any part of the proceedings when a complaint is being considered.

b. The Board may request professional or technical assistance from the Society's retained General Counsel or from any Executive Employee of the Society, including attendance upon any part of the Board's proceedings except its executive sessions. Should it become necessary in the opinion of the Board to take verbatim testimony in any case, the Board may obtain the services of a certified shorthand reporter licensed by the State of Colorado for such purposes, under the provisions of Rule 5-k.

c. In the event the Board reaches the point, in any investigation, where the Board feels it should file and prosecute charges against a physician before any judicial body, the Board will, before filing such charges, consult with the retained General Counsel of the Society to determine the sufficiency of the evidence.

d. Any person retained or employed by the Society who through the operations of these Rules attains knowledge of a complaint pending before the Board shall be subject to the same rules of confidence and secrecy imposed upon members of the Board.

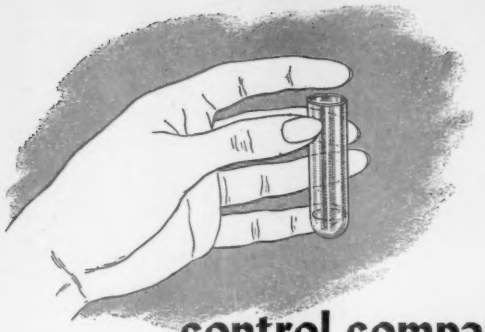
5. **General Procedure:**

a. The Board will receive complaints either verbally or in writing from any person, whether or not he or she be a physician, a member of the Society, an employee of the Society, a patient of a physician, or any other person, lay or professional.

b. The Board will respect the completely confidential nature of any complaint, provided that any complainant unwilling to appear personally before the Board will be given to understand that such unwillingness prejudices against the possibility of the Board being able to make a complete investigation. Every complainant will be invited to appear before the Board with the assurance that even the fact of his appearance before the Board, as well as the origin of the complaint, will be kept confidential; provided however, that should any form of prosecution result the Board will of necessity reveal the names of prospective witnesses; even though these names may include that of the complainant.

c. The Secretary of the Board will acknowledge receipt of all complaints, either verbally or in writing as the circumstances of each case indicate to be wiser. The Secretary will likewise, in consultation with the Chairman, arrange for meetings of the Board with such frequency as may be necessary so that investigation of each complaint is carried out with reasonable dispatch, and will notify complainants and any other persons whom the Board wishes to interview concerning meeting dates and places. The Secretary will, at all times, keep the Chairman informed concerning the progress of investigations conducted otherwise than at meetings of the Board.

d. The Acting Chairman, on receipt of information from the Secretary concerning each new complaint, shall determine whether first investigation or action on the complaint should be made by the whole Board in meeting, or whether an informal investigation should first be made by assignment (a) to one or more members of the Board who are not residents of the same area as the physician being complained against, (b) to an appropriate Board or Committee of a Component Society, or (c) to one or more members of the Society selected by this Board for this specific purpose. Any persons to whom such an assignment is made shall promptly report their



control companion to ACTH and CORTISONE

"In clinical practice it is clearly wise to test the urine of both diabetic and non-diabetic patients for sugar at intervals during administration of cortisone or ACTH and to carry out appropriate investigations and treatment if glycosuria occurs. Particular caution is necessary for diabetic patients."

Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

To avoid such clinical surprises and simplify clinical control, ACTH and cortisone therapy is profitably *preceded*, *accompanied* and *followed* by routine testing for urine-sugar. *Clinitest* Reagent Tablets provide a rapid, reliable and convenient method—easily used by both physician and patient.

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findings to this Board in writing, and in all instances shall bear in mind the confidential nature of these investigations. Similar procedures may be carried out to expedite any investigation initiated by this Board on its own motion.

e. When an informal investigation like that referred to next above has convinced at least two members of the Board (not including the member in whose district the physician under investigation resides) that no disciplinary action is indicated and that both the complainant and the physician involved are willing to accept the advice of the Board for reconciliation of the complaint, the advice and suggestions of the Board shall be reduced to writing and supplied to both complainant and the physician concerned, over the signature of the Acting Chairman.

f. When an informal investigation like that referred to in "d" above convinces any disinterested member of the Board that disciplinary action is indicated, the entire Board except the member whose district is involved shall consider the matter formally in meeting before further action is taken, and further action shall be determined by majority vote of those present.

g. When, after investigation and attempts to effect amicable settlement, the Board is unable to reconcile differences over fees charged by a member of the Society, the Board shall by a majority vote determine the fee which it deems fair and proper. In case the Society member shall agree to the amount so fixed and shall fail to abide by his agreement, the Board of Supervisors shall cite such member before the Board of Councilors for contempt proceedings. Failure of the member to agree to such determination of the Board of Supervisors shall constitute grounds for the preferring of charges of unprofessional conduct under the principles of ethics.

h. Whenever the Board determines to file charges against a member of the Society with either a Board of Censors or the Board of Councilors, the charges shall be reduced to writing and filed over the signature of two officers of the Board and over the typed signatures of all other members of the Board who have taken part in the proceedings.

In the event that, in consideration of a case involving complaint against a physician who is not a member of the Medical Society, it is determined that disciplinary charges should be filed against the doctor with a Board of Censors or the Board of Councilors were he a member of the Society, but it is also determined that the evidence does not justify proceedings before the State Board of Medical Examiners or a criminal court, the Board shall reduce its findings to writing, and subject to advice of legal counsel, shall notify the physician concerned of its findings and shall file a copy of this notice with the executive office of the State Society and the Secretary of the State Board of Medical Examiners for future reference.

i. Both the original complainant and the physician against whom the complaint has been made will be furnished with a written statement and explanation of the final decision of the Board as soon as possible after the Board has completed its investigation of the case, whether (1) the Board considers the case closed or (2) decides to file charges with a judicial body.

j. Immediately after each meeting of the whole Board, the officers of the Board shall prepare and deliver to the executive office of the Society, a memorandum suitable for inclusion in the monthly News Exchange, concerning any non-secret actions taken or general advice arrived at concerning the status of ethical deportment within the Society. In the event it is desired that such material be made the subject of a special bulletin to the entire membership of the Society, the Board shall make this decision known to the Executive Secretary.

k. Whenever the Board determines that contemplated actions of the Board, other than bulletin services indicated next above, will require use of certified shorthand reporters, telegraph or long distance telephone service, travel expense, or other matters involving State Society finances aside from routine services of the executive office, the Board will notify the Board of Trustees of the Society through the Executive Secretary, and estimate the financial requirements of the action then contemplated.

l. Officers of the Board shall keep appropriate and sufficient records of all of its final actions, other than confidential matters, and shall prepare quarterly reports of progress to the Board of Trustees and an annual report and recommendations to the House of Delegates.

m. Until further notice, the Board will meet regularly at 2:00 p.m., on the last Saturday of each calendar month in the Executive Office of the Society, subject to the privilege of the Chairman to postpone any such meeting if the date is impractical.

...As revised by the Board of Supervisors in meeting January 26, 1952

Revision Approved by the
Board of Councilors,
February 13, 1952

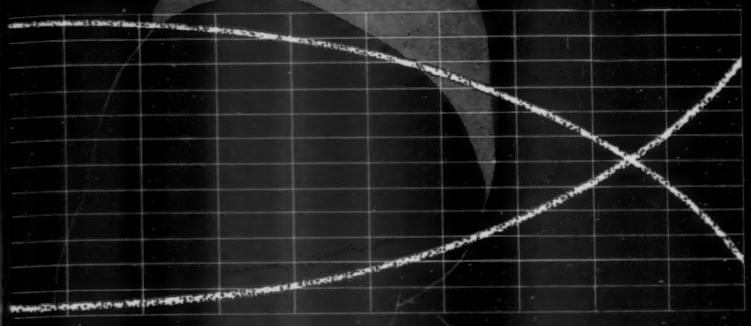
Component Societies

NORTHEAST COLORADO

In publishing Component Society "New Officers" in the February issue an error was made in the Northeast Colorado Society listing. The following officers were elected as of January 1, 1952: L. W. Anderson, Sterling, President; Frank Dille, Holyoke, Vice President; Kenneth H. Beebe, Secretary.

Dr. Irvin E. Hendryson of Denver, orthopedist at Children's Hospital, was the guest speaker for the February meeting of the Northeast Colorado Medical Society. The meeting was held February 7 at Ovid, and was followed by a social hour at the home of Dr. Fred Hilderman.

K. H. BEEBE, Secretary.



demand and supply

Stress states may bring about an increased *demand* for corticoid hormones that even a physiologically hyperactive adrenal cortex may fail to meet. In the shock following severe infections, burns, or major surgery, and in prolonged convalescence, the problem of *supply* may be answered by subcutaneous, intramuscular or intravenous injection of Upjohn Adrenal Cortex Extract.

Upjohn Adrenal Cortex Extract

Upjohn research in adrenal structure and function has aided the practice of medicine by the development of extracts which provide all of the natural adrenal cortical hormones.

Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent to 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol 10%.

Supplied in 10 cc. and 50 cc. vials.

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for Medicine . . . Produced with care . . . Designed for health

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DR. JOHN S. BOUSLOG ELECTED PRESIDENT AMERICAN COLLEGE OF RADIOLOGY

At the annual meeting of the American College of Radiology that took place on February 8, 1952, in Chicago, Dr. John S. Bouslog of Denver was elected President of the College. Doctor Buslog has served a four-year term on the Board of Chancellors of the College and was chairman of the Board from June, 1950, to June, 1951.

Northeast Colorado Cancer Seminar

An all-day seminar on cancer, designed particularly for the physicians of the northeast quarter of Colorado and southeast Wyoming, will be held Sunday, April 6, in the new Community Hospital at Fort Morgan, Colorado.

To sponsor the seminar, the "Northeastern Colorado Cancer Association" has been created as an informal grouping of the Northeast Colorado Medical Society, the Morgan County Medical Society, and the Washington-Yuma Counties Medical Society. All interested physicians, however, regardless of residence or membership in any of these three component societies of Colorado, are invited to attend. There will be no registration fee.

The following subjects and speakers will appear on the program:

Dr. Emmett A. Mechler, Denver: Cancer of the Cervix and Uterus.

Dr. Harvey W. LeFevre, Denver: Cancer of the Colon.

Drs. Kenneth D. A. Allen and John H. Freed, Denver: Cancer of the Breast From the Radiologist's Standpoint.

Dr. Karl F. Sunderland, Denver: Cancer of the Breast From the Surgeon's Standpoint.

Dr. Peter C. Hoch, Denver: Cancer in Childhood.

Dr. Henry M. Lewis, Denver: Cancer of the Skin.

Auxiliary

WOMAN'S AUXILIARY TO THE COLORADO STATE MEDICAL SOCIETY

Eight nurses throughout the state received $50.00 scholarships. They were chosen by the Health Education Committee from letters of recommendation by their respective superintendents. The letters and notes received from these girls are very sincere and appreciative.

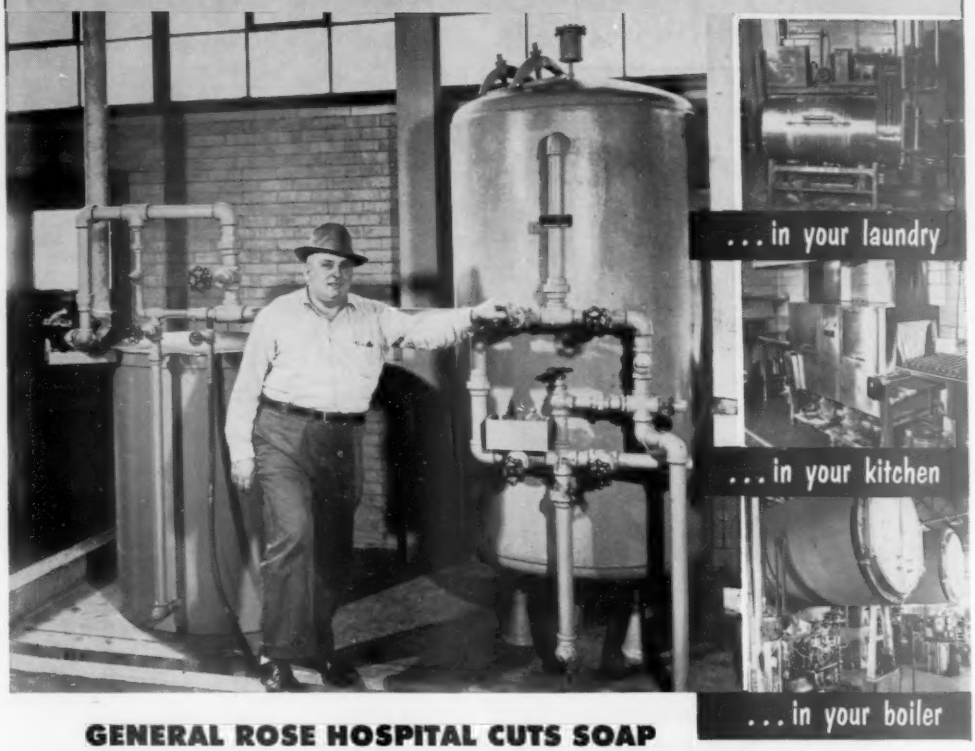
There were twenty-two requests from superintendents of various nursing schools. The scholarships granted are to Mercy, Presbyterian, St. Luke's, St. Anthony's, Children's and Denver General Hospitals, all of Denver; De Paul Hospital, Pueblo, Colorado, and La Junta Mennonite Hospital, La Junta, Colorado.

MRS. CLARK HEPP.

THE WOMAN'S AUXILIARY SPONSORS TRAFFIC SAFETY EDUCATION

In cooperation with the State Department of Highway Safety and local Safety Councils, the wives of Colorado physicians are lending their support to the campaign for safer driving through the use of films, booklets, qualified speakers, press and radio.

HARD WATER COSTS YOU MONEY



GENERAL ROSE HOSPITAL CUTS SOAP COSTS 80%—REDUCES HEATING FUEL AFTER USING A

WESTERN INDUSTRIAL WATER SOFTENER

General Rose Memorial Hospital, Denver, has eliminated costly hard water by installing a Western Industrial Zeolite Water Softener.

John Delmonico, General Rose heating plant superintendent (pictured above), reports no scale in his boiler because he uses soft water from Western Softeners. Besides the corrosive action on pipes and boiler tubes, mineral deposits form an insulation which requires up to 25% more fuel.

Records in General Rose Hospital prove that they cut their soap bill 80% by using a Western Water Softener. You can get these profit savings with a Western Water Softener, yourself.

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Find out how you can cut costs and improve sanitation by writing the Western Filter Company, today. A factory engineer will design a water softening unit to fit your exact specifications.

Please send me information on the Western Industrial Water Softeners with Special Hospital Application, and how I can increase profits and reduce sanitary hazards with soft water.

*Name*_____ *Title*_____

*Hospital*_____

*Address*_____

*City and State*_____

Mail to: Western Filter Co., 4545 East 60th Avenue, Denver 16, Colorado.

At their recent meeting in Denver Dr. Harry Bryan, President of the Colorado State Medical Society, commended the Auxiliary on its new project, saying, "After all, there is a great deal of money spent on such diseases as rheumatic fever, yet it doesn't affect nearly so many people as traffic accidents."

At this same meeting the film "And Then There Were Four" was shown to the ladies as being typical of the fine help available to them through the State Patrol. They were given posters, booklets and valuable suggestions by Mr. William Foulis of the State Highway Department and by Mr. Brandon Marshall of the Denver Safety Council.

The project of Traffic Safety for March is particularly devoted to Motor Manners for which Emily Post has written a special booklet. It is hoped that courtesy, patience, thoughtfulness, fair play and self-control will become part of driving manners, reducing injury and death by motor.

The Health Education Committee of the Woman's Auxiliary chose this project because of the findings of Frank G. Dickinson, Ph.D., medical and health statistician of the American Medical Association. In 1948, and many times since, he said to the National Auxiliary Presidents that, since medical science had made such strides in conquering common diseases and in lengthening the life span, anyone really interested in saving lives in the early and productive years would go into safety education. He gave figures to support his claim that death and injury by accident far exceeded death by disease during those years.

Looking at our own State of Colorado for 1949 and 1950, the figures speak for themselves and compel action! Traffic deaths, 705; injuries, 74,875. Polio deaths, 41; cases, 873.

MRS. A. A. WEARNER,
Member of Health Education Committee.

Obituaries

ANDREW S. BRUNK, M.D.

Dr. Andrew S. Brunk of Detroit, Michigan, an Honorary Member of the Colorado State Medical Society, died suddenly from a cardiovascular accident February 3, 1952, while vacationing in San Antonio, Texas.

Dr. Brunk, who practiced in La Junta, Colorado, from 1911 to 1924, received his medical degree from Ohio State College in 1909, and settled in Colorado soon thereafter. When he moved to Detroit in 1924 he soon became active in affairs of the Michigan State Medical Society and held many offices in that Society, including its Presidency. He was the founder and first President of the Conference of Presidents of State Medical Societies in 1945. He retired from a busy surgical practice two years ago, but still maintained activity in medical organization and was Treasurer of the Michigan State Medical Society until his death.

He was elected to the rarely accorded Honorary Membership in the Colorado State Medical Society only last September, in recognition of his many services in his profession in Colorado, in Michigan, and nationally.

Ideal Infant Feeding Formula

S-M-A®

S-M-A is a complete formula.

Unmatched in similarity to healthy mother's milk, S-M-A provides all essential food elements, including vitamins and minerals well in excess of recommended daily allowances.

S-M-A is an economical formula.

Only water need be added. Since the addition of nutritive elements is unnecessary, *the initial cost is the whole cost*. And the whole cost of the complete S-M-A formula is *less than 1¢ per ounce*.

S-M-A Liquid **S-M-A** Powder

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CARTER C. PERKINS

Dr. Carter C. Perkins was born in Farmington, Missouri, in 1873, and died February 6, 1952, in Altadena, California. Dr. Perkins came to Denver in 1907 and practiced medicine here for thirty-seven years before retiring in 1944. He was one of the earliest surgeons on the staffs of St. Luke's and Children's Hospitals and served as Chief Surgeon for the Denver division of the Burlington Railroad. He was associated with the City Health Department for several years. Dr. Perkins is survived by a son, Dr. James M. Perkins of Denver, and by a sister, Miss Etta Perkins of California.

EWING C. GUTHRIE

Dr. Ewing C. Guthrie was born in New Bloomfield, Missouri, in 1864, and died in Denver, February 11, 1952. Dr. Guthrie was a member of the staff of St. Luke's Hospital and practiced medicine in Denver for more than forty years. He was an active member of the Colorado State Medical Society until the time of his retirement when he was elected to Emeritus Membership. Dr. Ewing is survived by a son, Colonel Paul Guthrie, and a daughter, Mrs. Emil W. Christensen, both of Denver.

NEW MEXICO Medical Society

DR. CARL MULKY HONORED

Dr. Carl Mulky of Albuquerque was honored in Socorro January 31 at a New Mexico Medical Advisory Conference, sponsored jointly by the New Mexico Medical Society and the New Mexico Department of Public Welfare. The meeting was held at the State Tuberculosis Sanatorium.

The day was designated as "Carl Mulky Day," in recognition of Dr. Mulky's entering his fiftieth year of medical practice, his many services to the State of New Mexico, and his fight against tuberculosis.

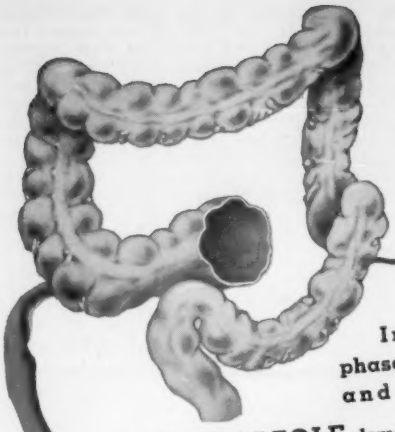
Among his achievements, Dr. Mulky has served as President of Bernalillo County Medical Society, the New Mexico Medical Society, and the New Mexico Tuberculosis Association; he is President of the New Mexico Trudeau Society, is a fellow of the American Medical Association, the American College of Physicians and the American College of Chest Physicians; he is Chief Consultant to the New Mexico State Tuberculosis Sanatorium, Consultant to the United States Indian Service and the United States Veterans' Hospital in Albuquerque. He has served as a Councilor to the New Mexico Medical Society for a great many years. He was elected the first honorary member of the New Mexico Medical Society at its 1951 Annual Meeting, in recognition of his signal contributions to the Society and the medical profession.

Obituary

ARTHUR J. EVANS, M.D.

Dr. Arthur J. Evans, Magdalena, died after a lengthy illness on January 28. Dr. Evans was born in 1883 and graduated from Louisville Medical College in 1905. He had practiced in New Mexico since 1908.

Dr. Evans practiced in Elida from 1908 until



"Efficiency... unquestioned."[1]

In controlling the active phases of NONSPECIFIC PROCTITIS and ULCERATIVE COLITIS . . .

NISULFAZOLE demonstrates striking initial improvement in general symptoms, and in reduction in number of stools. In protologic conditions, too, this sulfonamide brings highly satisfactory improvement with consequent better results.

Because it exerts "focal" action at the usual origin of the disease (rectum and proximal colon), NISULFAZOLE brings rapid relief and satisfactory end results, with some cases showing complete arrest for periods of more than one year.[2]

NISULFAZOLE, administered intrarectally, as a retention enema, tends to reduce lysozyme . . . checks indigenous bacteria . . . arrests necrosis. Consequent symptomatic improvement and high incidence of remission are welcomed by both physician and patient.

In your most refractory cases of NONSPECIFIC ULCERATIVE COLITIS and PROCTITIS, specify

NISULFAZOLE®

10% Suspension —
Brand of Paranitrosulfathiazole
Available in bottles containing 10 fluidounces.

Write Dept. MA for literature

1. Wills, C. B.: Rocky Mtn. Med. J. 46:743, Sept. 1949.
2. Swigert, William B.: J. Int. Coll. Surg., 14:714, Dec. 1950.

BREON

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1937. He was elected to the first New Mexico state senate in 1911. In 1915 he was named registrar of the U. S. Land Office at Fort Sumner by President Woodrow Wilson. From 1937 to 1947, Dr. Evans served the U. S. Army as a contract physician. He lived in Albuquerque from 1939 until 1941, and served as New Mexico District Health Officer in 1942 in District 8, the largest such district in the United States.

Dr. Evans was a past patron of the Eastern Star chapter at Elida and a member of the Scottish Rite bodies at Santa Fe, the New Mexico Medical Society and the American Medical Association.

MONTANA
Medical Association

Yellowstone Valley Annual Conference

The Yellowstone Valley Medical Association has announced preliminary program plans for its second annual Spring Conference to be held May 19 and 20 at Billings, Montana.

Guest speakers will include Drs. Alton Ochsner of New Orleans, Edgar V. Allen of Rochester; Minnesota; E. T. Bell of Minneapolis, and E. M. Hammes of St. Paul. In addition, there will be entertainment for doctors and for their wives.

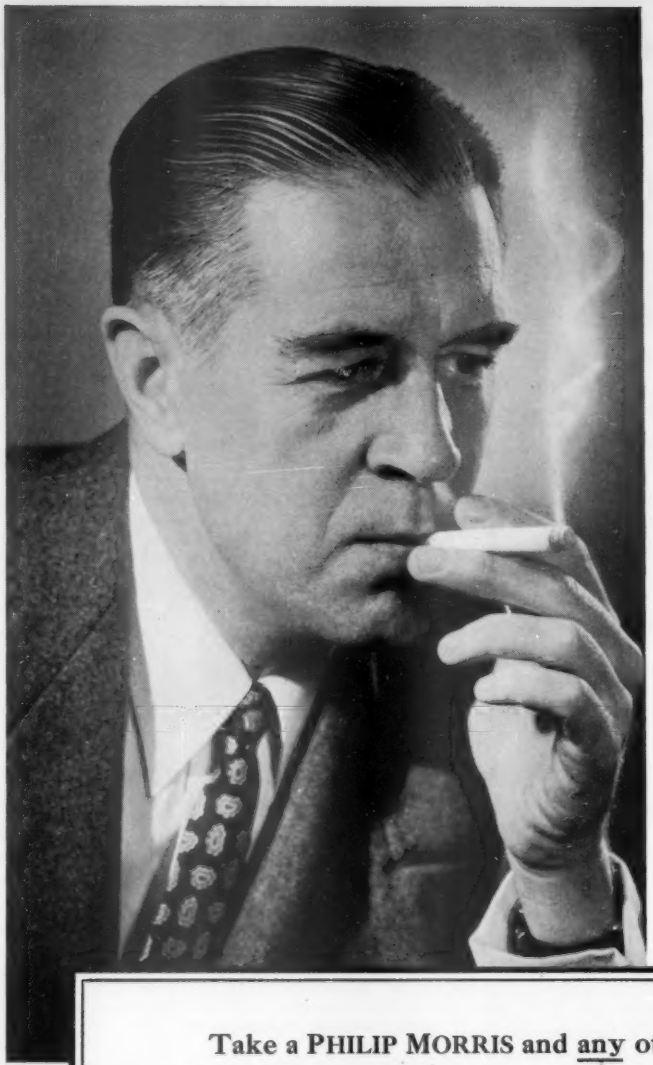
In view of the fact that a Shrine convention will immediately follow the medical meeting, possibly making hotel rooms difficult to obtain without advance reservations, physicians are urged to write for reservations long in advance. Reservation requests should be addressed to Dr. Roger A. Larson, 412 North Broadway, Billings.

WYOMING
State Medical Society

ANOTHER GOOD YEAR FOR BABIES!

The Wyoming State Health Department has released its annual list of the twenty Wyoming physicians who reported the largest number of live deliveries in the year just closed. The figures are for the complete calendar year of 1951, as follows:

E. W. Kunckel, Casper	263
L. D. Kattenhorn, Powell	227
B. J. Sullivan, Laramie	193
K. L. McShane, Cheyenne	178
R. O. Shwen, Cheyenne	159
R. H. Bowden, F. E. Warren Air Base	143
T. B. Croft, Lovell	133
S. J. Giovale, Cheyenne	129
G. M. Harrison, Rock Springs	127
A. A. Engelman, Worland	118
F. H. Haigler, Casper	114
O. L. Treloar, Afton	110
G. W. Koford, Cheyenne	110
E. S. Bovenmyer, Riverton	107
E. W. McNamara, Rawlins	103
W. Hart, Casper	103
Paul A. Kos, Rock Springs	99
R. F. Babskie, F. E. Warren Air Base	93
J. E. Hoadley, Gillette	91
R. B. Baker, Rawlins	87
J. W. Sampson, Sheridan	86
R. D. Ashbaugh, Riverton	82
Donald MacLeod, Jackson	82



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and <u>any</u> other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and <u>any</u> other leading brand.

PHILIP MORRIS

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UTAH
State Medical Association

OGDEN SURGICAL SOCIETY

The Ogden Surgical Society, famed for its annual spring meetings, has announced May 21, 22, and 23, 1952, as the dates for this year's annual session. Program plans are well under way and it is hoped they will be ready for publication in the April issue of the Journal.

Obituaries

GEORGE N. CURTIS, M.D.

Dr. George N. Curtis, Salt Lake City physician, died November 19, 1951, of a coronary occlusion.

Dr. Curtis was a graduate of Northwestern University School of Medicine, having graduated from that school in 1913. He began his practice in Salt Lake City in 1914. He served as Secretary of the Utah State Medical Association from 1935 to 1936 and was President of the organization in 1937. From 1939 until 1944 he was Superintendent of the Salt Lake General Hospital.

Dr. Curtis was an active member of the Church of Jesus Christ of Latter-Day Saints. He served a mission to the northern states in 1905 to 1907.

Dr. Curtis is survived by his widow; four sons, Dr. George H. and David H. Curtis, both of Salt Lake City, Dr. Homer C. Curtis of Philadelphia, and Dr. Clifford H. Curtis of San Francisco; a daughter, Mrs. Lucile Braithwaite of Boise, Idaho.

F. W. TAYLOR, M.D.

Dr. Fredrick W. Taylor, prominent retired Provo physician and surgeon, died Friday, January 11, 1952, at his home in Provo.

Dr. Taylor was born July 18, 1866, in Salt Lake City, Utah. He attended Salt Lake City schools and later the University of Deseret. He was graduated from the Medical School of New York University.

Beginning his practice in Provo, Dr. Taylor was instrumental with Dr. J. W. Anid and Dr. George E. Robinson in the establishment of the Provo General Hospital and Nurses Training School and was instrumental in the establishment of the modern Utah Valley Hospital. He was a Past President of the Utah State and Utah County Medical Associations.

Dr. Taylor is survived by his widow, Amelia Richards; three sons and four daughters, Heber R. Taylor, Salt Lake City; Dr. Fred R. Taylor, Palos Verdes, California; Dr. A. R. Taylor, Cheyenne, Wyoming; Mrs. Lloyd Finlayson, Mrs. Milton Marshall, Mrs. Stanley Cox and Mrs. Milton J. Woods, all of Provo, Utah.

JAMES P. KERBY, M.D.

Dr. James P. Kerby of Salt Lake City, Utah, pioneer radiologist and internationally known physician, died Saturday, January 26, 1952, after a long illness.

Dr. Kerby was born in Washington, D. C., August 28, 1886. He completed his medical training at Johns Hopkins University and George Washington University and did postgraduate work in hospitals in Philadelphia, Chicago, and New York.

Dr. Kerby was a Past President of the Utah

Meat and its Important Contribution of Essential Minerals

With the exception of calcium and iodine,[1] meat, as customarily consumed, makes an important contribution to the mineral needs of the American people. Its minerals include those needed in substantial amounts as well as those needed in trace amounts only.

The array of data listed below gives the approximate amounts of essential minerals provided by muscle meat when seven ounces per day are consumed.[1] The minerals include those now known to be essential components of the human organism—the skeletal framework and teeth, soft tissue structures including blood, and substances concerned in regulatory functions.

APPROXIMATE MINERAL CONTENT OF MEATS

200 Gm. (approx. 7 oz.),[1] Edible Portion (Uncooked)

	Beef Round	Lamb Leg	Pork Loin	Veal Shoulder
Minerals, total[2]	2.0 Gm.	1.8 Gm.	1.8 Gm.	2.0 Gm.
Calcium[3]	22 mg.	20 mg.	20 mg.	22 mg.
Chlorine[3]	147 mg.	136 mg.	125 mg.	147 mg.
Copper[3]	0.2 mg.	0.2 mg.	0.2 mg.	0.2 mg.
*Iodine[4] (Ohio animals)	0.02 mg.	0.03 mg.	Data not available	0.01 mg.
Iron[3]	5.8 mg.	5.4 mg.	5.0 mg.	5.8 mg.
Magnesium[3]	46 mg.	42 mg.	39 mg.	46 mg.
Phosphorus[3]	360 mg.	426 mg.	372 mg.	398 mg.
Potassium[3]	661 mg.	610 mg.	559 mg.	661 mg.
Sodium[3]	164 mg.	152 mg.	139 mg.	164 mg.
†Cobalt[5]	0.0002 mg.	———	Data not yet available	———
†Manganese[3]	0.03 mg.	0.03 mg.	0.02 mg.	0.03 mg.
†Zinc[5]	9.4 mg.	———	Data not yet available	———

*Iodine content of meat varies with the iodine content of feed of the animals.
†Needed in trace amounts only.

The average values for iron, phosphorus, and copper of the four kinds of meat shown constitute about 46, 25, and 100 per cent, respectively, of the National Research Council's recommended daily allowances for adults, and the average values for chlorine, potassium, and sodium constitute about 14, 63, and 16 per cent, respectively, of the estimated daily adult needs, as based on mineral balance studies.[6] Although no specific information is available on the quantitative needs for cobalt, magnesium, manganese, and zinc, nutrition information would suggest that the amounts reported above have nutritional importance or significance.

In addition to its notable content of essential minerals, meat also furnishes large amounts of biologically complete protein and important amounts of vitamin B complex, which includes biotin, choline, folic acid, inositol, niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and vitamin B_{12}. On the basis of its rich contribution of nutritional essentials, meat well deserves its prominent place in the daily diet of the American people, the world's best-nourished people.

1. Recent estimates of the U. S. Department of Agriculture indicate that the per capita consumption of meat in the United States approaches seven ounces per day.
2. Watt, B. K., and Merrill, A. L.: Composition of Foods—Raw, Processed, Prepared, In Agriculture Handbook No. 8, United States Department of Agriculture, 1950.
3. Estimated on basis of protein content of meats. Sherman, H. C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 153.
4. Ohio animals; varies with iodine content of feed. Johnson, H. J.: Bridges' Dietetics for the Clinician, ed. 5, Philadelphia, Lea & Febiger, 1949, p. 800.
5. Mitteldorf, A. J., and Landon, D. O.: Analytical Chemistry; Spectrochemical Analysis of Beef for Mineral-Element Content, Armour Research Foundation of Illinois Institute of Technology. In Press.
6. Dauphinee, J. A.: Sodium, Potassium, and Chloride Malnutrition, Including Water Balance and Shock, in Jolliffe, N.; Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, p. 341.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

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State Medical Association and the Salt Lake County Medical Society. He served as a member of the House of Delegates of the American Medical Association from 1945 to 1949. He was a member of the Rocky Mountain Radiological Society, the Radiological Society of America and the American Roentgen Ray Society. He was a director of the American Cancer Society, Utah Division. He was a delegate to the Inter-American Radiological Society meeting in Santiago, Chile, in 1949, to the International Radiological Society Conference in Paris in 1940, and to the International Cancer Society convention in London in 1950.

He was a member of the Catholic Church and an honorary life member of Serra International Salt Lake Chapter, and a Fourth Degree member of Knights of Columbus, Salt Lake Council No. 602.

Dr. Kerby is survived by a son, James P. Kerby, Jr., Salt Lake City; two sisters, Mrs. Florence K. Younger, Salt Lake City, and Mrs. Paul Hummer, Washington, D. C., and a grandson.

BLUE CROSS and BLUE SHIELD

NEW PHYSICIANS' SERVICE DEPARTMENT

To better serve the physicians of Colorado, The Colorado Medical Service, Inc.—The Blue Shield Plan—is developing a Physicians' Service Department. It is hoped that this department will foster a clearer appreciation and understanding of the problems which daily confront both the participating physician and the Blue Shield Plan.

The initial step taken by the Physicians' Service Department has been the writing of a Participating Physicians' Manual. This manual, which is in the process of being printed and bound, will be given to all participating physicians to use as a guide in their dealings with the Blue Shield Plan. Care has been exercised to cover all phases of "Operation Blue Shield"—the plan itself, the Service Statement, the Fee Schedule, and, when applicable, the Veterans' Care Program, with enough detail to appraise the physician, or his office assistant, of exactly what to expect in behalf of their Blue Shield patients.

When the time comes for distribution of the new manual, an effort will be made to contact all participating physicians personally. This will take time, certainly, but each recipient will have an opportunity to discuss the contents in detail. Further, if permission can be obtained, Blue Shield would like to hold a series of meetings with the many office secretaries, receptionists, or assistants who in daily practice are as concerned with the functions of the Blue Shield Plan as the participating physician himself. Permission has already been granted by a large number of physicians who are willing to give the time for their assistants to attend such a meeting.

Like a child learning to roller-skate, the Physicians' Service Department will doubtless suffer bumps and bruises before it gains its balance. But "practice makes perfect"—and with practice the department will become a service in fact as well as name.

RUBBER STAMP

A doctor in San Francisco plans to use a rubber stamp—a duplicate of the new A.M.A. office plaque—on his monthly statements as an added incentive to his patients to talk over questions of professional services and fees, thereby building a feeling of mutual understanding between physician and patient.

COLORADO
Medical School Notes

SEWALL LECTURE

Dr. Samuel A. Levine, distinguished cardiologist from Boston, has been chosen Henry Sewall Lecturer this year. The Sewall Lecture will be given the evening of Tuesday, April 15, in the Denison Auditorium. The subject will be "A Plea for the Stethoscope."

The annual Nu Sigma Nu Lecture will be given by Dr. Merrill C. Sosman of Boston on Thursday evening, April 17, in the Denison Auditorium.

All members of the Colorado State Medical Society and all visiting doctors in the Rocky Mountain region are cordially invited to attend these two lectures. Further announcement will be made later.

POSTGRADUATE COURSE "INTERNAL MEDICINE FOR THE GENERAL PRACTITONER"

A three-day postgraduate course is being offered to physicians of the Rocky Mountain area on March 20, 21, and 22, 1952, at the University of Colorado Medical Center. This course is designed for discussion of aspects of internal medicine of particular interest to the general practitioner. Bedside instruction in small groups and clinics with case presentations will be featured in the three morning sessions.

Two guest clinicians will participate in the course. Dr. Loren W. Shaffer is Professor of Dermatology and Syphilology at Wayne University College of Medicine, Detroit, Michigan, and Consultant to the United States Public Health Service. Dr. Edgar S. Gordon is Associate Professor of Medicine at the University of Wisconsin Medical School. In addition to their participation in the postgraduate course Doctor Shaffer and Doctor Gordon will present lectures in the Denison Memorial Library Auditorium at 4:00 p.m. on March 20 and 21, respectively. These lectures will be open to all physicians without registration or fee.

Doctor Shaffer's subject will be "Diagnostic Problems and Modern Treatment of Venereal Disease." He has recently returned from a medical mission to Europe and the Near East and will present the latest information in this field.

Doctor Gordon's subject will be "The Neuro-Endocrine Control of Physiological Processes." He has made outstanding contributions to our knowledge of the action of ACTH and Cortisone.

The registration fee for the postgraduate course is $5.00 and the tuition will be $20.00. All applications and inquiries should be sent to the Director of Graduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

FIVE NEW P.G. COURSES ANNOUNCED

The University of Colorado School of Medicine has announced a series of five new courses in graduate and postgraduate medical education.

These additional courses will include complete surveys on the latest developments in internal medicine, gynecology, obstetrics, poliomyelitis, traumatic and emergency surgery and psychiatry. Course instructors will feature prominent guest lecturers, in addition to members of the C.U.

School of Medicine faculty. All courses will be held at the University of Colorado Medical Center in Denver.

Here are the courses and the highlights of each:

March 20 to 22—"Internal Medicine for General Practitioners," a practical course devoted to recent advances in diagnosis and treatment of common medical diseases. Professor Gordon Meiklejohn, head of the Department of Medicine, and his staff will instruct.

April 10 to 12—"Gynecology, Obstetrics, and Related Problems of the Newborn," featuring as guest lecturers Professor Emil G. Holmstrom, University of Utah; Professor William C. Keettel, University of Iowa; Professor Gilbert J. Vosburgh, Western Reserve University, and a guest pediatrician, in addition to the C.U. faculty.

May 1 to 3—"Poliomyelitis," a review of diagnosis and management of polio patients. Course instructors have had wide experience in managing cases in the recent Colorado outbreaks.

May 19 and 20—"Traumatic and Emergency Surgery," will include discussions in fractures, burns, shock, antibiotics and other drugs, transfusions and acute abdominal conditions.

June 26 to 28—"Psychiatry for General Practitioners," will be aimed to present prevalent physchiatric concomitants in general medicine. Guest lecturer will be Dr. William T. Shanahan, Professor of Psychiatry at the University of Texas.

POSTGRADUATE SEMINAR IN OBSTETRICS AND GYNECOLOGY AND IN PROBLEMS RELATED TO THE NEWBORN

Sponsored by the Department of Obstetrics and Gynecology School of Medicine
University of Colorado

April 11 and 12, 1952
Denison or Sabin Amphitheatre

Registration and Tuition — $20.00

PROGRAM
April 11, 1952

MORNING

9:00—The Use of Dihydroergotamine (DHE 45) During Labor—Paul D. Bruns, M.D.

9:30—The Problem of Induction of Labor—William C. Keettel, M.D.

10:00—The Early Diagnosis of Cancer of the Ovary—Jerome S. Harris, M.D.

10:30—Treatment of Fibromyomata—Warren W. Tucker, M.D.

11:00—The Diagnosis and Treatment of Leukorrhea—N. Paul Isbell, M.D.

11:30—Surgical Procedures Designed to Improve Fertility—Lyman W. Mason, M.D.

AFTERNOON

2:00—Hydatidiform Mole and Chorio-epithelioma—E. Stewart Taylor, M.D.

2:30—Present Concepts of Rh Problems and Hemolytic Disease of the Newborn—Emil G. Holmstrom, M.D.

3:00—Fetal Wastage of Early Pregnancy—Gilbert J. Vosburgh, M.D.

3:30—The Obstetrician's Responsibility in Safeguarding the Newborn—Lloyd V. Shields, M.D.

4:00—Care of the Handicapped Newborn: (a) Prematurity; (b) Infection in the Newborn; (c) Resuscitation of the Newborn—Herbert C. Miller, M.D.

WANTADS

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April 12, 1952

MORNING

9:00—Postmenopausal Bleeding — Jerome S. Harris, M.D.

9:30—Medical Complications of Pregnancy — Emil G. Holmstrom, M.D.

10:00—Use of Regional Anesthesia in Obstetrics —Ben C. Williams, M.D.

10:30—Fibrinolytic Syndrome—C. Houston Alexander, M.D.

11:00—Place of Version and Extraction in Present-Day Obstetrics — William C. Keettel, M.D.

11:30—Uterine Inertia — Gilbert J. Vosburgh, M.D.

Visiting Faculty

Jerome S. Harris, M.D.—Fellow, Department of Obstetrics and Gynecology, Columbia University, College of Physicians and Surgeons, New York City.

Emil G. Holmstrom, M.D.—Professor of Obstetrics and Gynecology, University of Utah.

William C. Keettel, M.D.—Associate Professor of Obstetrics and Gynecology, University of Iowa.

Herbert C. Miller, M.D.—Professor of Pediatrics, University of Kansas.

Gilbert J. Vosburgh, M.D.—Professor of Obstetrics and Gynecology, Western Reserve University.

Faculty, University of Colorado

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General Information

This course will include a survey of problems met in the general practice of obstetrics and gynecology and will emphasize various aspects of the specialty which lead to fetal morbidity and mortality.

Requirements

This course is open to all physicians who are graduates of accredited medical schools and/or members of their respective county medical societies. The registration fee is $5.00 and the tuition fee, $15.00. All residents and interns and members of the faculty of the University of Colorado School of Medicine are cordially invited to attend the lectures without charge.

Application

All applications should be sent to the Director of Graduate and Postgraduate Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colorado. Registration fee must accompany the application (this fee is not refundable).

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April 11 and 12, 1952

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Detach and send with $5.00 registration fee payable to the University of Colorado and address to Director, Graduate Medical Education, 4200 East Ninth Avenue, Denver, Colorado.

Tuberculosis Abstracts

Issued Monthly by the National Tuberculosis Association

Vol. XXV MARCH, 1952 No. 3

MASS ROENTGENOGRAPHIC SURVEYS IN SMALL HOSPITALS

Russell H. Morgan, M.D., The American Review of Tuberculosis, September, 1951.

When mass roentgenographic procedures were applied to the tuberculosis case-finding program a few years ago, it was soon realized that the patients admitted to general hospitals constituted a large and readily accessible group in which the yield of positive cases was considerably greater than that occurring in mass surveys of other groups. Hodges demonstrated that the incidence of tuberculosis among the patients admitted to the University of Michigan Hospital was 2.3 per cent. Moreover, the detection of other pathology brought the total yield of significant lesions to almost 10 per cent.

There has been a rather slow acceptance of mass roentgenographic procedures among hospitals having capacities of 50 to 250 beds. This has been due, in part, to the understandable reluctance of attending radiologists to undertake a burden of some magnitude without a reasonable return. In the larger teaching hospitals many of the radiologists have provided routine small-film examinations at no cost to the patient—a policy which has caused some health authorities to advocate free routine chest examinations in all hospitals. This thinking, however, is not necessarily sound when applied to small hospitals.

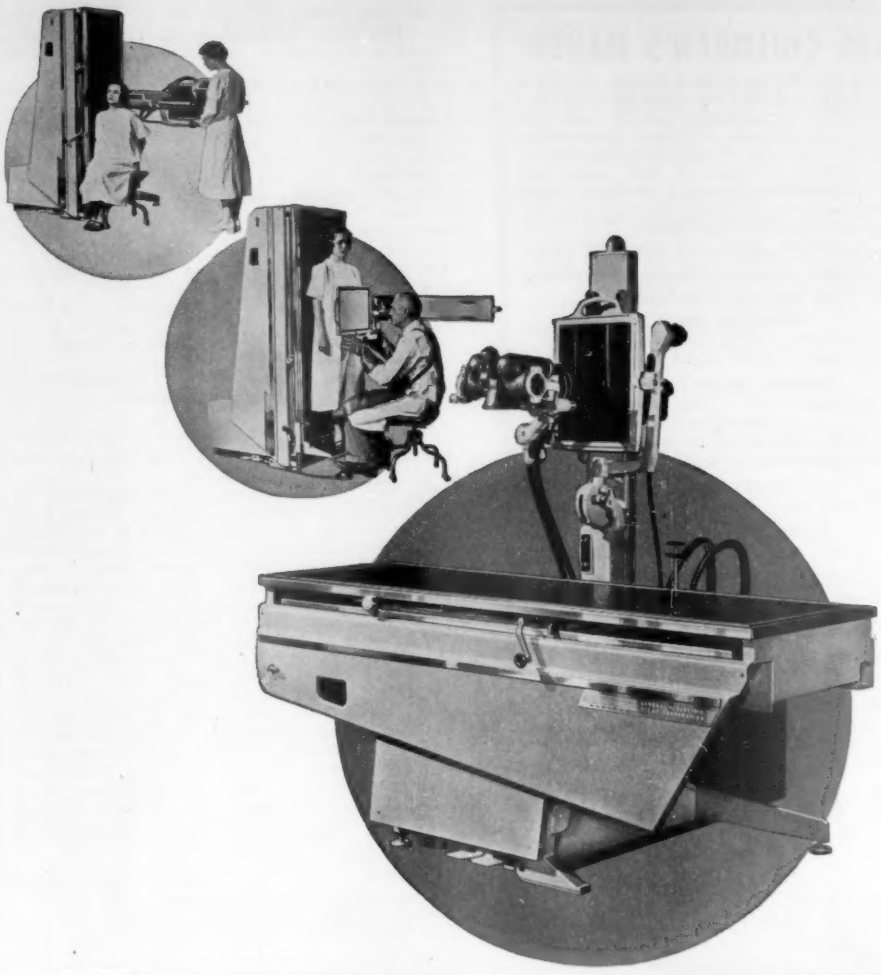
In many small hospitals, funds are not available to furnish a mass photofluorographic installation from operating revenues and the radiologist may provide the necessary equipment. If this is the case, free routine admission chest films can hardly be insisted upon. Ten to twelve thousand dollars will be required for the installation and a charge of about $1.50 per chest film will be necessary. This charge for a miniature chest film is a reasonable levy. The frequent detection of unsuspected pathology makes them worth many times their cost to the persons with pulmonary lesions. Thus, where public funds are not available to install a routine chest unit in a small hospital, each patient should be charged a nominal sum for the unit's support. Indeed every local tuberculosis association should examine its budget to determine whether money is available to demonstrate the value of the procedure. Many times a little added support will make successful mass chest survey programs in small hospitals possible.

Another reason for the slow acceptance of routine photofluorographic examinations in small general hospitals has been the erroneous belief that these procedures become inefficient and costly when numbers less than fifty to one hundred are to be examined each day. To illustrate this point let us examine the situation in a large general hospital and then adapt it to a hospital having a capacity of 100 beds.

The technical cost of performing a photofluorographic examination may be divided into the following categories:

(a) Amortization on capital equipment
(b) Service to capital equipment
(c) Photofluorographic supplies such as film and developer
(d) Personnel, including technician, secretary, and such other persons as are necessary
(e) Rental of floor space
(f) Utilities, including light, heat, telephone, and laundry.

In a large hospital about 15,000 examinations are performed each year. The service charges usually average five cents per exposure or $750 for 15,000 examinations. These charges will be incurred when x-ray tubes, valve tubes, or other components require replacement. The



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cost of photofluorographic film and other supplies for units using 70 mm. film also amounts to approximately seven cents per exposure or $1,050 for 15,000 examinations.

The personnel needs of a photofluorographic installation will vary. However, where the yearly number of examinations approaches 15,000 one x-ray technician and one clerk-typist are needed. These individuals register the patients, make and process the films, record reports from the radiologists who read the films, and file the films and reports. The floor space needed usually approaches 500 square feet. At a nominal rental such space represents an expense to the procedure of $1,500. Electric power and telephone service may approach $300.

The technical cost of operating a photofluorographic unit in a large general hospital may be:

(1)	Amortization of capital equipment	$ 1,500
(2)	Service charges	750
(3)	Film and developing chemicals	1,050
(4)	Personnel	5,100
(5)	Floor space	1,500
(6)	Utilities and miscellaneous expense	300
	Total	$10,200

The technical cost per routine chest film in a large hospital approaches seventy cents.

Let us now examine a hospital with a capacity of 100 beds and 2,000 or more admissions per year or eight admissions per day. In such a hospital an economical arrangement can be achieved usually by placing a photofluorographic hood and cut-film camera within a room of the department of radiology. The capital equipment in a department of radiology today costs approximately $7,500. The regular case-load in a hospital of this size approaches sixteen patients per day. Since the photofluorographic portion of this load constitutes one-third of the total, one-third of the cost of capital equipment (or $2,500) should be amortized against the routine chest procedures. To perform the photofluorographic examinations a hood and cut-film camera will be needed. Even in a small hospital, photofluorographic procedures are more economical. If all the equipment is amortized on a ten-year basis and 2,000 examinations were done each year the total equipment costs would be about 25 cents per film. The costs of service, film and developing chemicals, and personnel will approach $100, $140, and $700, respectively.

The technical budget for a small 100-bed hospital performing routine chest examinations might include:

Amortization of capital equipment at hand	$ 250
Amortization of photofluorographic apparatus	250
Service	100
Films and developing chemicals	140
Personnel	700
Floor space	500
Utilities and extras	50
	$1,990

If 2,000 examinations are performed within this budget, the technical cost per examination would be just under one dollar, which is only 50 per cent greater than that encountered in a large general hospital. This difference clearly indicates that from an economical standpoint mass chest surveys are feasible in small hospitals.

Nothing has been said regarding the professional fees of the radiologist who reads the routine chest films of a small hospital. It seems unreasonable that a physician who makes his living from radiological methods should forego revenue from so time-consuming a procedure. These charges, which usually approximate 50 cents per film, bring the total cost of the photofluorographic examination in a small hospital to approximately $1.50.

Most small hospitals should have a mass radiographic equipment which could be used to serve the community as well as the hospitals.

In this abstract the author has changed some of the figures used in the original article in order to bring them more in line with the current situation.

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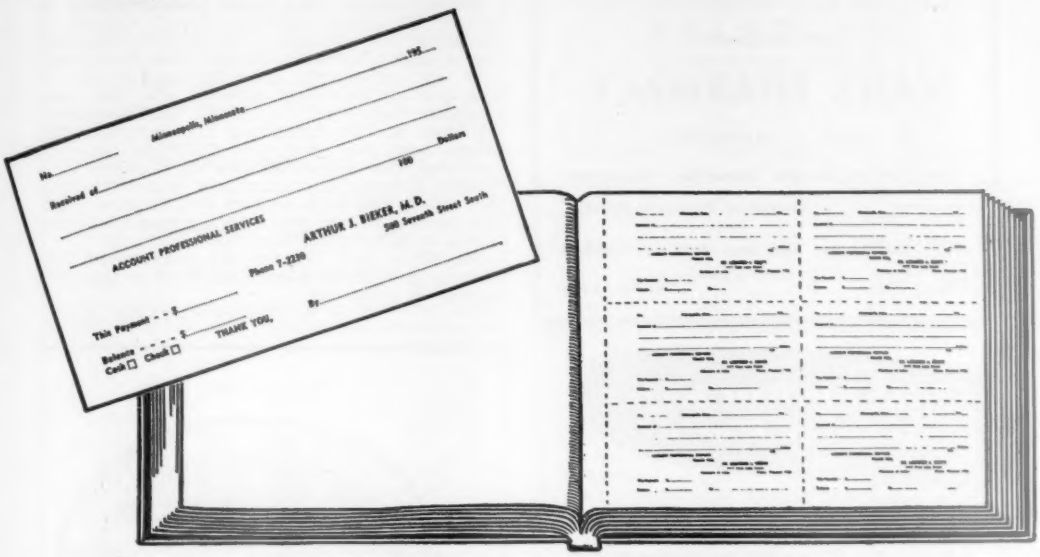

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BOOK CORNER

Book Reviews

Natural Childbirth, a Manual for Expectant Parents: By Frederick W. Goodrich, Jr. Prentice-Hall, Inc., New York. Price, $2.95.

Dr. Goodrich, a former resident in obstetrics at Yale, has written a book to prepare the expectant mothers for delivery with limited medication, in the Grantly Dick Read tradition. He believes, as does every intelligent obstetrician, that ignorance of the mechanisms of labor and lack of familiarity with hospital procedures add greatly to the patient's pain at delivery.

The anatomy and physiology of the reproductive organs, diet, exercises, means of relaxation, typical hospital procedures, and the psychology of labor are discussed in this very complete manual. The author recommends breast feeding and rooming-in along with "natural childbirth."

Many patients who have been schooled in Read's "Childbirth Without Fear," written in the grand and sweeping style, have a deep feeling of guilt and failure if they have an opisiotomy and anesthesia. Dr. Goodrich treats all this in a matter-of-fact manner, with less emotionalism than Read. One of his most important warnings is: "Do not forget that having medication does not constitute a failure on your part and does not reflect on your ability as a mother. Experience with women who have done this shows that such women will require much less medication and will have a pleasanter experience in labor than those who have not."

We think that doctors can recommend this book to patients who are interested in this philosophy of obstetrics.

E. STEWART TAYLOR, M.D.

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